City of Blair, Nebraska
Request for FMLA
(Family and Medical Leave Act of 1993)

Please return form to
Benjamin Guhl
Fax: 402-426-4195
Phone: 402-426-6689

Employee Name: _____ Employee ID or SSN: _____

Supervisor Name: _____

I. **ELIGIBILTY**

An employee is eligible for FMLA who has been employed with the City of Blair, Nebraska for at least 12 months **and** who has worked at least 1250 hours during the past 12 months. I **[select one]** DO ☐ DO NOT ☐ meet the eligibility requirements for FMLA.

II.. **REASONS FOR LEAVE**

I request FMLA leave for the following reason [select one]:

☐ a) The birth of your child, or the placement of a child with you for adoption or foster care

☐ b) A serious health condition that makes you unable to perform the essential functions of your job

☐ c) A serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care

III. MEDICAL CERTIFICATION & FITNESS FOR DUTY

I understand that if my leave is because of (b) or (c) above, my, or my family member's, doctor or practitioner may be required to certify the serious health condition. If so, I will submit that certification to the City of Blair prior to my leave, if the leave is foreseeable, or within 15 days after the date I receive the *Notice to Employee Requesting FMLA Leave*, and the certification must be submitted on the *Certification of Health Care Provider form*. If I do not provide the certification as requested, I understand that my leave may be denied or discontinued until I do.

I understand that I must also complete a *Fitness for Duty* certification if the leave is for my own serious health condition. The certification must be submitted prior to returning back to work. If the certification is not received, I understand that m return to work may be delayed until the certification is provided.

IV. TIMING OF LEAVE [select one]

☐ I request that my FMLA leave begin on _____, and continue for complete workdays through _____.

☐ I request that my FMLA leave begin on _____, and continue for certain portions of my normal workday through _____. Describe special workday/ time arrangements:

V. ELECTION TO CONTINUE COVERAGE UNDER OTHER BENEFIT PROGRAMS

I **[select one]** ☐ DO ☐ DO NOT want the City of Blair to maintain my coverage under the *City of Blair Employee Health Plan* during the period of my FMLA leave. I understand that if I elect to maintain coverage, I must make premium payments to the City as described in the Notice to Employee Requesting FMLA Leave.

I **[select one]** ☐ DO ☐ DO NOT want the City of Blair to maintain my coverage under the *City of Blair Insurance Plan (e.g. life insurance, disability insurance, etc.)* during the period of my FMLA leave. If you are without pay for a full calendar month, you will need to contact this office to determine the cost for maintaining the coverage. If you have not made arrangements by the 1st of the following month, those benefits will been canceled.

VI. USE OF ACCRUED PAID LEAVE

I understand that Sick Time must be used [docked simultaneously with FMLA leave as applicable based on my eligibility or I will be required to substitute accrued aid leave for un aid FMLA leave.

VII. INTENT TO RETURN TO WORK

If I do not return to work after the 12 weeks of protected leave, I understand that my position will no longer be protected, and I could be terminated. I **[select one**] DO ☐ DO NOT ☐ intend to return to work upon expiration of this FMLA leave.

I acknowledge that completion of the *Request for FMLA* form does imply that the leave will be approved. I understand that the approval for FMLA is subject to meeting eligibility qualifications as set forth by the Department of Labor and the City of Blair Nebraska will notify me of my approval status in the *Notice to Employee Requesting FMLA Leave.*

_____ _____
Employee's Signature DATE

_____ _____
Employer's/HR Signature DATE