Application for Family Medical Leave

Employee Name: _____ PERNR: _____
Regular Hours Worked Per Week: _____ Email: _____
Home Address: _____ Contact Phone #: _____
Agency Name: _____

Purpose of Family Medical Leave:
(example: birth or placement of a child, employee serious health condition, family member's serious health condition, leave for qualifying family member's military leave)

_____
_____
_____
Attach supporting documentation, if required.

Anticipated dates/duration of leave: Beginning: _____ End: _____
Total workdays: _____

Please check one of the following:

◯ **I do not wish to reserve any accumulated sick leave while utilizing family and medical leave concurrently with my accumulated paid leave** pursuant to 101 KAR 2:102 Section 3(6) and/or 101 KAR 3:015 Section 3(6).

◯ I **request to reserve _____ days (not to exceed 10) of my accumulated sick leave while utilizing family and medical leave concurrently with my accumulated paid leave** pursuant to 101 KAR 2:102 Section 3(6) and/or 101 KAR 3:015 Section 3(6). I understand that this may cause a portion of my family and medical leave to be without pay.

*** Family and Medical Leave events eligible for employer paid leave shall use FMLA concurrently with employer paid leave and shall exhaust all employer paid leave prior to use of other accrued leave.**

Employee Certification: In requesting Family and Medical Leave, I certify that all information on this application is true and that I will abide by the laws governing FMLA.

_____ _____
Employee Signature Date

FOR AGENCY USE ONLY:
Family and Medical Leave Request is:
◯ DENIED Reason: _____
◯ APPROVED Dates: Beginning: _____ End: _____
Family and Medical Leave (FMLA) balance as of this date: _____
Date Family and Medical Leave Designation Letter sent: _____
This FMLA event meets the requirement of Employer Paid Leave? ◯ YES / ◯ NO

Printed Name of Appointing Authority or Designee	Signature of Appointing Authority or Designee	Date