Application for Family Medical Leave

Employee Name _____ Personnel Number _____

Agency Name _____

Agency Address _____

Regular Hours worked Per Week _____

Home Address _____

Home Phone (_____) _____ Work Phone (_____)_____

PURPOSE of Family and Medical Leave (for example: birth or placement of a child, own serious health condition, family member's serious health condition, leave for qualifying family member's military leave):
_____
_____
_____.

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 _____ (not to exceed 10) days 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.

Attach supporting documentation, if required.
Anticipated duration of leave from _____ to _____ for a total of _____ workdays. In requesting family leave, I certify that all information on this application is true and that I will abide by the regulations governing family leave.

_____ _____
Employee Signature Date

FOR AGENCY USE ONLY:

Family and Medical Leave Approved _____ for dates _____ to _____

Family and Medical Leave Denied _____ Family and Medical Leave Balance as of this date _____

Date Family and Medical Leave Designation Letter sent _____

_____ _____
Signature of Appointing Authority or Designee Date