City of Miami

FMLA (Family and Medical Leave Act) Request

REFERENCE: Family Medical Leave Act of 1993, applicable collective bargaining agreements, City of Miami Administrative Policy No. 3-08

OVERVIEW

This form should be completed and submitted to the Labor Relations Division, before leave commences, when forseeable. If leave is approved, accrued leave time balances shall be used concurrently with FMLA time. In the event that accrued leave time is exhausted prior to return from leave, the employee must contact Risk Management to make arrangements for repayment of health insurance premiums. Authority to grant and designate leave under FMLA rests with the Human Resources Director.

1. Name:	2. Title:	3. Date:
4. Department:	5. Contact Number:	6. Employee ID No.:

7. ☐ **Regular Full-Time Employee** ☐ **Part-Time/Temporary Employee** **** (Employees are eligible if they have been employed for at least 12 months and worked 1,250 hours during preceding 12 month period.)***

REASON FOR LEAVE

☐ **Birth of a child or placement of a child for adoption or foster care**

☐ **A serious health condition that makes the employee unable to perform functions of his/her position**
(Must submit Physician or Practitioner Certification within 15 days)

☐ **A serious health condition affecting your ☐spouse/domestic partner ☐child ☐parent ☐grandparent for which you are needed to provide care (Must submit Physician or Practitioner Certification within 15 days)**

☐ **Qualifying exigency - arising from ☐spouse/domestic partner ☐son/daughter ☐parent being on active duty or called to active duty status in support of contingency operation as a member of the National Guard or Reserves**

☐ **To care for a family member (□ spouse/domestic partner ☐son ☐daughter ☐parent ☐next of kin) who incurred a serious injury/illness as a result of active military service**

This request is for: ☐ **Full-Time Leave** ☐ **Intermittent/Reduced Leave**

Effective Start Date of Leave: _____

Anticipated Return Date: _____

Have you utilized FMLA in the past 12 months? □ **Yes** □ **No** **If so, please provide dates.** _____

*** As part of my request for leave under FMLA, I understand that I may be required to submit medical/supporting documentation. This information is used to determine whether this request for leave qualifies for coverage under the Family and Medical Leave Act (FMLA). I understand that failure to provide any requested documentation could result in the delay or denial of my FMLA request.**

_____ Employee's Signature

_____ Date

☐ **Approved**

☐ **Disapproved**

_____ Human Resources Director

_____ Date