

**TOWN OF BOOTHBAY**

**FAMILY MEDICAL LEAVE REQUEST FORM**

Employee Name: \_\_\_\_\_ Dept: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Hire: \_\_\_\_\_  Full time for last 12 months  Other

Duration of Leave - Beginning \_\_\_\_\_ Ending \_\_\_\_\_

- Regular FMLA Leave \_\_\_\_\_
- Intermittent Leave \_\_\_\_\_
- Reduced Leave Schedule \_\_\_\_\_

**Reason for Leave**

- Employee's Own Serious Health Condition, including any period of incapacity due to pregnancy, prenatal medical care or childbirth.
- Care for the employee's spouse, domestic partner, son, daughter, domestic partner's child, sibling or parent (but not in-law) who has a serious health condition.
- Care for the employee's child after birth, or placement for adoption or foster care.
- Due to a qualifying exigency arising out of the fact that an employee's spouse, son, daughter, parent, sibling or domestic partner is a covered military member on active duty or has been notified of an impending call or active duty status in the National Guard or Reserves in support of a contingency operation.
- Due to donation of an organ of that employee for a human organ transplant.

Please provide further explanation of above request: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note: You do not need to provide private health information.

Additional Information: \_\_\_\_\_  
(if any) \_\_\_\_\_  
\_\_\_\_\_

I understand that FMLA policy provisions are outlined in the Employee Handbook, and that FMLA leaves are governed by federal and state laws. I further understand that this request for FMLA leave will be reviewed, and I will be notified in a timely basis as to its approval or denial, and any related conditions.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Completed Form to be returned to the Business Office.