

Family and Medical Leave Act Request

Name:		Date:
Position:	Supervisor:	
Hire Date:	Anticipated Start Date of Leave:	Anticipated Date of Return:

Eligibility for leave:

I have at least twelve months service with the State of Nebraska. (**Note:** Service may be with more than one Agency -- service need not be continuous.) YES NO

I have been paid for at least 1,250 hours of work by the State of Nebraska in the past twelve months. (**Note:** Does not include paid leave or paid Holiday hours.) YES NO

Reason for leave (check the reason that applies below):

Note: FMLA Leave under the following circumstances must be completed no later than one year after the child's birth, adoption, or foster care placement.

- Birth of a child. The child's birth date or expected birth date is _____.
- Adopting or have legally adopted a child. The date of child's placement in my home was/is _____.
- Placement of a foster child in my home. The date of child's placement in my home was/is _____.

Note: In each case below, a serious health condition is defined as requiring one of the following: (1) inpatient care, (i.e. an overnight stay); (2) a period of incapacity of more than three consecutive calendar days, and treatment two or more times by a health care provider, or treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider; (3) incapacity due to pregnancy or prenatal condition (4) a chronic condition requiring at least two visits per year for treatment by a health care provider; or (5) a permanent/long-term condition requiring supervision This does not include voluntary or cosmetic treatments unless inpatient hospital care is required.

- My own serious health condition that prohibits me from performing the essential functions of my position (*would include recovery from childbirth or extended pre-natal care*).
- Care for my seriously ill mother or father. (*if not your biological or adoptive parent, you must present satisfactory evidence of parental relationship -- care for a mother-in-law or father-in-law does not qualify for FMLA Leave*)
- Care for my seriously ill spouse. (*must be legal spouse; unmarried domestic partners do not qualify for FMLA Leave*)
- Care for my seriously ill child. (*must be under 18 years of age; or 18 years of age or older and incapable of self-care because of a mental or physical disability. If not your biological, adoptive, foster, or step-child, you must present documentation of parent-child relationship*)

Military Leave Provisions of the Family and Medical Leave Act:

Qualifying Exigency Leave-Personal request due to exigencies arising out of the fact my spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard, Reserves, or regular duty Armed Forces personnel who are deployed to a foreign country, in support of a contingency operation.

Note: In the case below, a **Serious Injury or Illness of Covered Service Member Certification Form** must be completed and returned within 15 calendar days of submission of this form.

Military Caregiver Leave-I am the next of kin of a covered service member who has a serious illness or injury incurred in the line of duty, while on active duty.

Have you taken a leave of absence under this policy during the preceding 12 months? Yes No

If yes, how many workweeks or hours have you taken? _____

Are you requesting intermittent leave or a reduced schedule? Yes No

Will you be using paid leave during your absence? (If the absence exceeds 40 hours then use of available paid leave is required. All paid leave used which exceeds 40 hours runs concurrently with unpaid FMLA) Yes No

Acknowledgment:

I must see that my health care provider completes and sends to HR a **Family and Medical Leave Health Care Provider's/Practitioner's Certification Form for Employee's Serious Health Condition or Family Member's Serious Health Condition** within **15 calendar days** of the date I submit my request form.

I must complete and submit to HR a **Family and Medical Leave Insurance Coverage Continuation Form**.

Authorization for the release of medical information may be necessary for my own serious health condition or that of a family member.

I understand that Human Resources will evaluate my request for a family/medical leave and notify me whether my request has been approved or denied.

I understand that any paid leave exceeding 40 hours taken for any FMLA reason will count against the twelve (12) week FMLA entitlement.

I understand that FML that exceeds 40 hours in a twelve (12) month period, beginning with the date of first use, will require that any available sick leave, vacation leave or comp time be used concurrently with the FML. However, vacation leave may be reserved in an amount up to 40 hours, unless Catastrophic leave is requested.

During unpaid absences, sick and vacation leave will not accrue and holidays will not be compensated.

My service date will be adjusted if my unpaid absence exceeds fourteen (14) consecutive calendar days.

If my absence from work is due to my personal health condition, I may be required to submit a "Return-to-Work/Fitness-for-Duty" certification from my Health Care Provider prior to my return to work.

When I return to work at the end of the approved FMLA leave period, I will be returned to the same job I left.

Failure to return to work at the end of my leave period may be treated as a resignation or may subject me to disciplinary action, including termination unless an extension has been agreed upon and approved in writing.

Obtaining the initial medical certification shall be at my expense. NDE may require a second opinion from a health care provider of NDE's choice and at NDE's expense. If the second opinion differs from the first, a final and binding third opinion may be sought from a mutually agreed upon health care provider at NDE's expense.

Under the Family and Medical Leave Act, I must make reasonable efforts to schedule planned treatments or the use of intermittent Family and Medical Leave on a reduced schedule so as not to unduly disrupt the employer's operations.

NDE may require recertification of the medical condition.

When foreseeable, I must apply for Family and Medical Leave a minimum of 30 calendar days in advance. In cases where it is not foreseeable, it is my responsibility to apply for Family and Medical Leave as early as possible and practicable.

I have been notified of the **Genetic Information Nondiscrimination Act (GINA) Title II**, which prohibits employers and other entities covered by GINA Title II from requesting genetic information of employees or their family members.

Employee's Signature:

Date:

Approval:

Human Resources:

Approved Denied

Date: