



Diocese of Great Falls-Billings
 PO Box 1399
 Great Falls MT 59403
 406-727-6683
www.dioceseofgb.org

Family and Medical Leave Act (FMLA) Request Form

What is FMLA?

FMLA is leave for up to 12 weeks without pay which allows an employee to retain their job and benefits for qualified family and medical reasons. To be eligible for FMLA, employees are required to have worked for the company at least 12 months and worked a minimum of 1,250 hours during the preceding year. If the employee has met those requirements, have the employee complete this form. All sections must be completed to be considered for FMLA leave.

To be completed by the employee:		
Employee Name	Job Title	Phone #
Reason for Leave of Absence: <input type="checkbox"/> Birth of a child and to bond with a newborn child <input type="checkbox"/> Placement of a child for adoption or foster care and to care for the newly placed child <input type="checkbox"/> Care for the employee's spouse, child or parent with a serious health condition <input type="checkbox"/> Own serious health condition <input type="checkbox"/> Military FMLA Leave		Answer all questions below: Yes / No <input type="checkbox"/> <input type="checkbox"/> Do you have company medical insurance? <input type="checkbox"/> <input type="checkbox"/> Do you have company dental insurance? <input type="checkbox"/> <input type="checkbox"/> Do you have company vision insurance?
Requested Start Date:	<input type="checkbox"/> Continuous Leave <input type="checkbox"/> Intermittent Leave	

- I understand that I am requesting the FMLA Certification of Health Care Provider Form (this will be mailed or emailed as indicated above) and will return the form to the Diocese of Great Falls Chancery, Human Resources Department.
- I understand that a Certification of Health Care Provider form must be returned to Human Resources within **30 days**. If this information is not received in the required timeframe, my leave may be considered "not approved" and any absences will be counted as unapproved absences.
- I understand that if I am not able to return the form within the allowed timeframe, I will contact Human Resources for assistance.
- I understand that if my FMLA leave is approved, my time away from work will be charged against my 12 week FMLA leave.
- I understand that upon approval of this requested leave, I may use any accumulated leave balances (sick and vacation) available prior to going into an unpaid leave status.
- I understand that upon approval of this requested leave, I will not lose my benefits during my leave.

Acknowledgement:

Employee Signature _____ Date: _____

For HR use only: Form Date Received: _____	FMLA Approved: Yes _____ No _____ FMLA Start Date: _____
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For questions or concerns about FMLA leave, please contact Human Resources at 406-727-6683 or HR@diocesegfb.org