Diocese of Great Falls-Billings
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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:	Answer all questions below:
☐ Birth of a child and to bond with a newborn child ☐ Placement of a child for adoption or foster care and to care for the newly placed child ☐ Care for the employee's spouse, child or parent with a serious health condition ☐ Own serious health condition ☐ Military FMLA Leave	Yes / No ☐ ☐ Do you have company medical insurance? ☐ ☐ Do you have company dental insurance? ☐ ☐ Do you have company vision insurance?
Requested Start Date:	☐ Continuous Leave ☐ 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 my principal.

☐ I understand that a Certification of Health Care Provider form must be returned my principal 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 my principal 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:	FMLA Approved: Yes _____ No _____
Form Date Received: _____	FMLA Start Date: _____

For questions or concerns about FMLA leave, please contact your school principal.