CITY OF PEMBROKE PINES
EMPLOYEE REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)

Additional information about employee FMLA rights and responsibilities will be provided to you in writing within five (5) business days after receipt of this notice (unless already provided). Determination of eligibility for leave under the FMLA, and/or additional documentation or clarification of documentation, may be required prior to making a final FMLA determination to approve or deny an FMLA leave request. Please contact Human Resources with any questions.

Name		Employee #		Position
Department				Supervisor Name
Home Street Address				Apt/Unit#
City	State	Zip	County	
Home Phone		Cell Phone		Personal Email
Requested Leave Start Date		Estimated Leave End Date		

SELECT REASON FOR THIS FMLA LEAVE REQUEST:
(SELECT THE MOST APPROPRIATE OPTION)

- ☐ Birth of a Son or daughter and to care for the newborn child.
- ☐ Placement with the employee of a son or daughter for adoption or foster care.
- ☐ To care for the employee's spouse, son, daughter or parent with serious health condition.
- ☐ A serous health condition that makes the employee unable to perform the functions of the employee's job.
- ☐ A qualifying exigency arising out of the fact that the employee's spouse, son, daughter or parent is a military member on covered active duty (or has been notified of an impending call or order to covered active-duty status).
- ☐ To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the covered service member.

TIME OFF WORK IS EXPECTED TO BE:

- ☐ For a **continuous** block of time (several continuous days, weeks or months off work).
- ☐ For a **reduced work schedule** (change is work schedule needed – fewer hours per day or fewer hours per week).
- ☐ On an **intermittent basis** (periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups/episodes of a medical condition and/or for ongoing medical treatments/appointments).

PAY STATUS DURING LEAVE

Eligible employees may elect, or the City may require employees to use their accrued leave (such as sick and vacation leave) during FMLA as long as the use is consistent with City Attendance and Leave policies. Requests to use leave as indicated below: (***Check all that apply***).

- ☐ Sick
- ☐ Vacation
- ☐ Leave without Pay
- ☐ Other Leave
- ☐ Combination of Accruals: (provide detailed information if you are requesting to utilize your accruals in a specific manner).

INSURANCE

While on FMLA, the City continues to pay the employer portion of health benefits. **The Employee** is responsible for continued payment of the employee portion of the premium. To arrange for payment of insurance premiums, **the Employee** must contact the Benefits Division in Human Resources at 954.392.2090.

Are you a current member of any of the following City-sponsored insurance plans?
(Select all that apply):

- ☐ Medical Insurance Plan
- ☐ Dental
- ☐ Vision

Have you or will you be filing a disability insurance claim? ☐ Yes ☐ No

FITNESS FOR DUTY STATEMENTS

Employees will be required to present a fitness for duty statement certifying that he/she is able to return to work prior to being reported to employment after returning from a continuous FMLA leave exceeding five (5) business days for their ***own serious health condition***.

I understand that I am required to complete a FMLA Leave Certification of Health Care Provider form and submit the form to Human Resources before my leave commences. I understand that the Certification of Health Care Provider form should be returned to Human Resources within 15 days. If I am not able to return the form within the allowed timeframe, I will contact Human Resources for assistance. If this information is not received in the required timeframe, my leave will be considered unauthorized.

I understand that if my leave is approved, my time away from work will be charged against my maximum leave entitlement under FMLA. Upon approval of this requested leave, I am required to utilize all paid time available to me prior to going into an unpaid leave status.

If I go into an unpaid status while on leave, I understand that I must contact Human Resources to make arrangements to pay my portion of health insurance premiums and that I may be required to be placed on COBRA while in unpaid status.

EMPLOYEE SIGNATURE: _____ DATE: _____

THIS SECTION FOR HR USE ONLY:	
Employee Name	**Employee #**
Date Received	**FMLA Eligibility Notice Sent**

___ Granted

___ Denied

___ Further information required as requested below: