401 3rd Ave NW | Austin, MN 55912 Ph 507.460.1903| Fax 507.355.2411

FAMILY & MEDICAL LEAVE REQUEST FORM

Please complete this form and submit it to the HR Department at District Office.
Employee must enter requested leave in AESOP or Skyward.

Section 1

Date: _____

Job Title: _____

Employee: _____

Immediate Supervisor: _____

Building: _____

If you are not eligible for FMLA, please skip to section 3

FMLA ELIGIBLE EMPLOYEES

- Has worked for the employer for at least 12 months;
- Has at least 1,250 hours of service for the employer during the 12-month period immediately preceding the leave
- Works at a location where the employer has at least 50 employees within 75 miles.

Section 2

This leave is for:

- ⬭ Birth/Adoption/Foster Care of a Child
- ⬭ Call to Active Duty of qualifying exigency
- ⬭ Care of Injured Service Member
- ⬭ Serious Health Condition of Self
- ⬭ Serious Health Condition of Family Member: (select one below)

Child /Spouse /Parent/Next of Kin Service Member

Section 3

Type of Leave: ⬭ Family ⬭ Medical ⬭ Military ⬭ Parenting

Anticipated Start Date: _____

Anticipated Date to Return to Work: _____

Please describe the reason/type of leave requested:

_____

_____

_____

If FMLA or Medical leave is approved, you will be required to use available allocations with the exception of 5 sick leave days.

Will you be using all allocations? Yes No

If yes, please provide the number of personal leave/PTO/vacation days you would like to use. _____

Will this leave be taken in an intermittent/reduced schedule? (ex.: work two days/week) Yes No

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If you have any questions regarding FMLA, please contact HR Assistant Jamie Norton (507-460-1903).

Employee's Signature: _____ Date: _____

Received by Human Resources: _____ Date: _____

Revised April 2018