



## CITY OF MANCHESTER

### REQUEST FOR FAMILY AND MEDICAL LEAVE

Employee Name: \_\_\_\_\_ Department: \_\_\_\_\_

Regular Work Schedule (indicate the days and hours worked): \_\_\_\_\_

I request a family and medical leave under the provisions of the Family and Medical Leave Act (FMLA) and the City of Manchester's Family and Medical Leave Policy. My reason for the request is (please check below:)

- \_\_\_\_\_ The birth of my child (Please check the reason for the requested leave).  
I understand the City will require medical certification from a health care provider.  
\_\_\_\_\_ Mother's pregnancy, delivery and post-partum recuperation  
\_\_\_\_\_ Parent's care for and bonding with newborn child  
\_\_\_\_\_ Mother's due date: \_\_\_\_\_ (or child's date of birth)
- \_\_\_\_\_ The placement of a child with me for adoption or foster care. I understand that I must provide a copy of the legal documents certifying this placement.  
\_\_\_\_\_ Child's date of placement: \_\_\_\_\_ (or anticipated date)
- \_\_\_\_\_ The need to care for my (circle one) SPOUSE, CHILD, PARENT with a serious health condition, or a BLOOD RELATIVE/WARD with a serious health condition who is living in my household. I understand the City will require medical certification from a health care provider.
- \_\_\_\_\_ The need to care for my (circle one) SPOUSE, CHILD, PARENT with a serious health condition. I understand the City will require medical certification from a health care provider.
- \_\_\_\_\_ My own serious health condition as defined under the FMLA. I understand the City will require medical certification from a health care provider.
- \_\_\_\_\_ To care for an injured or ill covered service member as defined under the FMLA. I understand the City will require medical certification from a health care provider.
- \_\_\_\_\_ Exigencies as defined under the FMLA pertaining to a covered family member's spouse, child or parent on covered active duty or called to covered active duty with the armed forces, in support of a contingency operation as either of the following:
- \_\_\_\_\_ A member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country. I understand the City will require certification of a qualifying exigency.
- \_\_\_\_\_ A member of a reserve component of the Armed Forces, duty during the Deployment of the member with the Armed Forces to a foreign country Under a call or order to active duty. I understand the City will require Certification of a qualifying exigency.

I understand that FMLA leave is unpaid, unless the employer requires that paid time off be taken prior to unpaid leave, and that I am entitled to take up to 12 weeks of FMLA leave (26 weeks for military caregiver leave), on a continuous or intermittent basis, during a 12 month period beginning on the first day of FMLA leave.

I am requesting a continuous leave of \_\_\_\_\_ days or weeks, commencing on or about \_\_\_\_\_ and ending on \_\_\_\_\_ .

I am requesting intermittent leave of \_\_\_\_\_ hours per day and/or \_\_\_\_\_ days per week, commencing on or about \_\_\_\_\_ and ending on \_\_\_\_\_ .

I further understand that the City of Manchester FMLA Policy requires that I use all paid time (Sick, Vacation, Personal) prior to any unpaid FMLA leave. When FMLA leave is taken for my own or a family member's serious health condition, accumulated paid time will normally be taken in the order of Sick\* (including Sick Bank credits if applicable), then Vacation, then Personal (if applicable). When FMLA leave is taken for parental bonding with a newborn child, the placement of a child due to adoption or foster care, or a qualifying military exigency, accumulated paid time will be taken in the order of Vacation, then Personal (if applicable).

\* The City of Manchester FMLA Policy, per City Ordinance, provides for the option of using accumulated Sick leave, upon approval of the Department Head, for absence due to the illness or injury of a spouse, child, or other blood relative or ward residing in the same household, or using other accumulated paid leave such as Vacation or Personal time. Please indicate below the type of accumulated paid leave you are requesting for FMLA leave to provide care for a family member (blood relative) residing in your household (subject to approval of Department Head):

\_\_\_\_\_ SICK

\_\_\_\_\_ VACATION/PERSONAL

In order to continue my health benefits coverage while I am on FMLA leave I understand that I must continue to make the appropriate employee contributions. Information concerning when and how to make the contributions will be sent upon approval of FMLA leave.

**This Request Form will not be considered valid unless signed by employee and Department Head (or designee).**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Department Head (or designee) Signature

\_\_\_\_\_  
Date