

**LENOIR COUNTY
EMPLOYEE'S REQUEST FOR FAMILY MEDICAL LEAVE**

EMPLOYEE NAME:

LAST FOUR DIGITS OF SS#:

DATE:

DEPARTMENT:

DATES OF LEAVE REQUESTED:

PAID UNPAID COMBINATION OF BOTH

PAID FMLA LEAVE PERIOD: BEGINNING DATE: _____

ENDING DATE: _____

UNPAID FMLA LEAVE PERIOD: BEGINNING DATE: _____

ENDING DATE: _____

INTERMITTENT LEAVE SCHEDULE: _____

ELIGIBILITY

1. Counting any periods of time that you worked for the county (whether they were consecutive or not), have you worked for the county for a total of 12 months or more? YES NO
(If "yes," continue to next question. If "no," stop here.)

2. During the past 12 months, have you worked at least 1,250 hours? YES NO
(If "yes," continue to next question. If "no," stop here.)

3. Have you previously received medical or family leave? YES NO
If yes, provide information below:

Dates of leave: From _____ to _____

Purpose of leave: _____

4. Have you taken any intermittent leave? If "yes," provide details: YES NO

EMPLOYMENT STATEMENT:

I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform my Department Manager by submitting a **NOTICE TO EMPLOYER OF CHANGES IN APPROVED MEDICAL OR FAMILY LEAVE(LC-002)** form.

MAINTENANCE OF HEALTH BENEFITS:

I elect to **continue** **discontinue** Group Health Plan benefits coverage until further notice. I understand that it is my responsibility to pay my share of the health plan premium to the employer monthly.

I have reviewed the Notice to Employees of Rights under FMLA and understand my rights and obligations, and the leave provisions granted under the FMLA of 1993 and January 2009 revisions. I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence and must submit the Certification of Health Care Provider form verifying my medical condition within 15 days after receipt of form or the County may delay the commencement of leave and/or approval of leave. I understand that failure to respond within the required timeframes may result in the loss of benefits, including job protection.

Employee's Signature

Authorized by Department Manager: _____ Date: _____

Reviewed by HR Director: _____ Date: _____