Family Medical Leave Act/Washington Family Leave Act

FMLA/WFLA Leave Request

Employees must provide at least 30 days advance notice of an anticipated FMLA leave. When the need for leave is not foreseeable, the employee must provide notice as soon as both possible and practical. The employer has no obligation to retroactively designate leave as FMLA. *A medical certification will be required for all FMLA leave requests except those for care of a newborn, placement of a child, or qualifying exigency. An FMLA designation notice will be provided for each FMLA request.*

To be completed by the employee OR the department.

Once received in Human Resources and FMLA eligibility has been determined, you will receive FMLA information within five business days. FMLA packets will be emailed to County emails or the email identified below.

EMPLOYEE Name: _____ Number: _____ Department: _____

Employee's Home Email address: _____ EXCEPTION: Mail to home address: ☐ YES

(ONLY if you don't want the FMLA information sent to your County email address)

Job Title: _____ Employee's Supervisor: _____

(EMPLOYEE's serious health condition only)

FMLA Request made by: _____ Date requested: _____

Anticipated date FMLA leave is to begin _____ to end _____

Qualifying reason Employee is requesting leave (check all that apply):

☐ Care of the employee's own serious health condition.

☐ Care of an employee's dependent with a serious health condition:

☐ spouse / same-sex domestic partner ☐ child ☐ parent ☐ In loco parentis

☐ (WFLA only) registered domestic partner ☐ (WFLA only) registered domestic partner child

☐ Care of a newborn, or the placement of a child due to adoption/foster care (Parental Leave Form required.)

☐ Workers' Compensation Injury (FMLA runs concurrent with W/C, no additional documents are required.)

☐ Qualifying exigency leave associated with call of active duty for:

☐ spouse / same-sex domestic partner ☐ child ☐ parent

☐ Care of a covered servicemember with a serious injury or illness who is the:

☐ child / child of the same-sex domestic partner ☐ parent ☐ next of kin

Once the above information has been completed, please return this form to the Human Resources Department via in person, OR by email to kitsapphs@co.kitsap.wa.us, OR fax to (360) 337-7187. PLEASE SEND THIS FORM ONE TIME PER LEAVE REQUEST. Due to time requirements, DO NOT put this form in the Interoffice mail.

FOR HUMAN RESOURCES USE ONLY:

Date of Hire: Employee has worked 1250 hours: ☐ YES ☐ NO

Previously used FMLA hours: _____ Leave Balance: *Annual* _____ *Sick* _____

Spreadsheet updated: _____ Date FMLA Information sent to Employee: _____

DOCTOR STATEMENT DUE: _____ Job Description Included: ☐ YES ☐ NO

If an employee has not been employed for twelve months (doesn't have to be consecutive) AND/OR has not worked at least 1250 hours during the past twelve months AND/OR the request is not for a family member listed above – DO NOT SEND AN FMLA PACKET. Pass information onto the FMLA Coordinator.