SARPY COUNTY

APPLICATION FOR LEAVE PURSUANT TO THE
FAMILY AND MEDICAL LEAVE ACT

Name: _____ Primary Phone: _____

Department: _____ Work Phone: _____

Last 4 digits of Social Security Number: _____

I request a family and medical leave of absence for the reason indicated below (check box that applies):

- ☐ Because of my own serious health condition which makes me unable to perform the functions of my job
- ☐ For the birth of my son or daughter and to care for the newborn child (anticipated delivery date): _____
- ☐ For placement with me of a child for adoption or foster care
- ☐ To care for my spouse, son, daughter, or parent with a serious health condition
  Name: _____ Relationship: _____
  If son or daughter, date of his/her birth (mm/dd/yyyy): _____
- ☐ To care for my spouse, son, daughter, parent, or relative to whom I am the next of kin who has an illness or injury incurred during active military duty
  Name: _____ Relationship: _____
- ☐ Because my spouse, son, daughter, or parent who is currently on or is being called to active military duty
  Name: _____ Relationship: _____

My leave will be (check box that applies):

- ☐ Consecutive leave beginning (mm/dd/yyyy) _____ and continuing to _____
- ☐ Intermittent/reduced beginning (mm/dd/yyyy) _____ and continuing to _____
  According to the following schedule: _____

_____

_____

_____

Complete only if you are providing care to a family member

State the care you will provide and an estimate of the period during which care will be provided. Use additional paper if necessary.

_____

_____

_____

_____

Does your spouse work for the County? ☐ Yes ☐ No If yes, please provide the following information:

Name: _____ Department: _____

I understand I am to give at least 30 days advance notice of the need to take FMLA leave when possible to do so.

I understand that after all requested paid leave is exhausted; any remaining leave will be without pay.

I understand that my leave may be delayed until the Medical Certification Form (which must be returned within 15 days) is returned if applicable.

I understand that in the case of my own serious health condition, I may not be permitted to resume my position with the County until I provide a completed "Return to Work Release" form.

I understand that if I do not return to work on the date indicated above (unless I have accrued leave remaining), my employment may be terminated by the County as of the date my leave expires.

_____ _____

Employee Signature Date

Employee: Submit this form to your Human Resource Department