



# FAMILY MEDICAL LEAVE ACT (FMLA) APPLICATION

Employees Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Work Location: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition or to care for a covered family member with a serious health condition. If requested, your response is required to obtain or retain the benefit of FMLA protections, pursuant to 29 U.S.C. §§ 2613, 2614(c)(3). If this leave is for a serious medical condition of yourself or a covered member of your immediate family, you must have the physician who is treating the individual complete the Medical Certification Statement form. Failure to provide a complete and sufficient medical certification may result in the denial of your FMLA request, pursuant to 29 U.S.C. § 825.313. You have at least fifteen (15) calendar days to return the Medical Certification Statement form to your employer, pursuant to 29 U.S.C. § 825.305, if it is not attached to this application.

Family Medical Leave may be granted for up to sixty (60) working days for maternity leave, paternity leave, adoption of a child or for the serious medical condition of yourself or a covered member of your immediate family for whom you are needed to be the primary care-giver. This leave is not given in addition to use of accumulated sick and/or vacation leave, use of sick bank leave, or worker's compensation leave but runs concurrently with your accumulated sick and/or vacation leave which begins on the first day of absence for any of the qualified reasons.

## ELIGIBILITY REQUIREMENTS:

**To qualify for Family and Medical Leave, an employee must meet the following criteria:**

1. Have been employed by the district for at least 12 consecutive months.
2. Have worked a minimum of 1,250 hours during the 12 months immediately preceding the leave.
3. Have a qualifying serious health condition or other eligible reason as defined below.

## QUALIFYING REASONS FOR LEAVE:

**Family and Medical Leave may be requested for any of the following reasons (please check which applies to you):**

- The birth of a child or the placement of a child with you for adoption or foster care.
- Your own serious health condition.
- To care for a family member with a serious health condition:
  - ( ) Spouse
  - ( ) Child
  - ( ) Parent
- Due to a qualifying exigency related to a family member's active duty or call to active duty status in support of a contingency operation:
  - ( ) Spouse
  - ( ) Son or Daughter
  - ( ) Parent
- To care for a covered service member with a serious injury or illness (up to 26 weeks of leave):
  - ( ) Spouse
  - ( ) Son or Daughter
  - ( ) Parent
  - ( ) Next of Kin

Please describe the type of care you will provide or require for your immediate family member, and indicate the estimated duration of leave needed.

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Anticipated date FMLA is to begin: \_\_\_\_\_ Anticipated date FMLA is to end: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RETURN TO THE HUMAN RESOURCES DEPARTMENT  
9461 BRANDYWINE LANE, PORT ST. LUCIE, FL 34986  
772-429-7501 (FAX)