FORM A
APPLICATION FOR FAMILY OR MEDICAL LEAVE

I hereby apply for family/medical leave for the following reason, (check one):

_____ Birth of my son or daughter and in order to care for my son or daughter

_____ Placement of a son or daughter with me for adoption of foster care

_____ Serious health condition affecting my ☐ spouse ☐ child ☐ parent, for which I am needed to provide care

_____ Serious health condition that makes me unable to perform the functions of my position

_____ In accordance with the National Defense Authorization Act of 2008 to care for a covered service member with a serious illness or injury incurred in the line of duty on active duty

_____ Qualifying "exigency" arising out of the fact that a covered military member is on active duty or called to active duty status in support of a contingency operation.

Leave period to being ____ / ____ / _____ and end on (through) ____ / ____ / _____
(You must have an estimated leave/return date)

I certify that I meet the eligibility requirements as set forth in the Family and Medical Leave Policy. If I am applying for leave because I have a serious health condition or a member of my immediate family does, I am supplying medical certification in accordance with the Family and Medical Leave Policy.

I authorize my employer to contact my treating health care provider for information or clarification about my medical certification. I agree to cooperate fully with my treating health care provider's course of treatment. I release any and all medical personnel with knowledge of my condition to communicate with my employer for the purpose of certifying or clarifying my certification. I agree that if my leave is due to my own serious health condition that before being permitted to return to work, I will present a certification from my health care provider that I am able to resume work (Form C).

I understand that I must pay my portion of health benefits, if applicable, by the first day of the month. I further understand that if I do not return to work after my leave for any reason but a continuance, recurrence, or onset of a serious health condition or other circumstances beyond my control, I will be obligated to repay to my employer the amount of my health insurance premiums that it contributed on my behalf during my leave. I agree that said repayment may be made by deductions from any remaining paychecks.

I understand that any FMLA leave might be otherwise substituted and reduced by paid leave in accordance with the Family and Medical Leave Policy. If I have been absent previously during this calendar year, I have attached Form A1, as a written explanation of this leave. I agree to supplement this explanation with medical certification if I am requested to do so by my employer.

_____ _____
Printed Name Address

_____ _____
Employee Signature Date

_____ _____
Employee Personal Email Address Employee Home/Cell Phone Number