REQUEST FOR FAMILY OR MEDICAL LEAVE

(This form is to be completed and filed by the employee with the SWTC administration office through the supervisor 30 days prior to the need to take FMLA leave when the need is foreseeable **or** as soon as possible.)

Name of Employee: ____
(Last) (First) (Middle)

Position: ____

Immediate Supervisor: ____

Length of Time Employed in SWTC: ____

This is a request to take FMLA for the following reason:
(Please indicate with a check.)

________ For the birth or placement of a child for adoption or foster care.

________ To care for an immediate family member (spouse, child, or parent) with a serious health condition.

________ To take medical leave because of inability to work due to a serious health condition.

A medical certification supporting the need for leave due to a serious health condition (affecting the employee or an immediate family member) is attached.

Anticipated date for the commencement of leave: ____

Anticipated date for return to work: ____

____
Signature of Employee Date