VA MEDICAL CENTER MEMORANDUM 05-13-03
ATTACHMENT "A"

Request for Family Leave Under the Family and Medical Leave Act

Employee Name _____

I have read the Medical Center Directive on Family and Medical Leave and am requesting leave:

○ Because of pregnancy
My expected delivery date is _____, _____
(Attachment "C" is not required, unless incapacitation period will extend beyond 6 weeks)

○ To care for my newborn son or daughter or my recently adopted child or my recently placed foster child.

Child's name _____
The child was/will be born/adopted/placed on or around _____, ____

○ To care for my spouse, child, or parent who has a serious health condition.

Name of family member _____
Relationship _____ If child, what is the child's age _____
(Attachment C, of this directive should be used to provide this information)

NOTE: If the FMLA leave requested is intermittent, the health care provider must provide anticipated frequency and duration for FMLA absences per 5 CFR 630.1208(b)(2). ***When are the treatments scheduled? How long does each appointment take? How often, in your provider's medical opinion, will the flare-ups occur? How many days, in your provider's medical opinion, will be missed from work for each flare up?***

I request to be allowed to begin leave on _____, _____.

I agree to return on _____, _____. If I learn that I will not be able to return on this date, I agree to call my supervisor immediately and to complete a new request for leave if one is required.

The total number of hours of leave I am requesting is _____
I plan to take _____ hours of sick leave (if appropriate)
_____ hours of annual leave
_____ hours of leave without pay
I agree to notify my supervisor immediately if my expected return date changes.

Please sign for one option below

(1) Signature _____ Date _____
(Medical certification, Attachment C, is enclosed)

(2) Signature _____ Date _____
(I am requesting FMLA be granted provisionally. I understand that I must provide the medical certification, Attachment C, within 15 days from the date of this request, or FMLA may be revoked).

Approved: Supervisor (signature) _____ Date _____
Supervisor (printed name) _____