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

Request for Medical Leave of Absence 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 to recover from my own serious health condition that renders me unable to perform the functions of my job. **(Attachment C, of this directive should be used to provide this information)**

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
_____ hours of annual leave
_____ hours of leave without pay

I agree to notify my supervisor immediately if my expected return date changes and will provide medical documentation supporting my return to duty.

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) _____

**** Attachment "C" to this directive should be used to provide this information***