CLARK COUNTY
FAMILY AND MEDICAL LEAVE POLICY

EMPLOYEE REQUEST FORM

NAME: ____DATE:___________________ EMPLOYEE #: _____________

DEPARTMENT: _______________________________________ POSITION/JOB TITLE: ________________________________

DATE OF HIRE: _______________________

STATUS: ❒ FULL TIME ❒ PART TIME

Dates of leave requested: From:____________________ To: ____________________

❒ I request intermittent leave (if applicable.).

Describe the length of each leave period (hours, days, etc.)

___

___

Reason for leave:

❒ The birth of my son or daughter and to care for such child;
Expected date of birth: _______________

❒ The placement of a son or daughter with me for adoption or foster care;
Date of placement: _______________

❒ To care for my spouse, son, daughter, or parent, (circle one) who has a serious health condition;
❒ *Check if parent-in-law.*

❒ My serious health condition
❒ My Worker's Compensation Injury

❒ Other (please explain the reason for the leave):

___

___

___

A PHYSICIAN'S CERTIFICATION WILL BE REQUIRED FOR ALL MEDICALLY RELATED LEAVES.

Substitution of Paid Leave: (Optional if on State leave, required on Federal leave.)

❒Vacation ________Hours

❒Compensatory Time ________Hours

❒

❒Sick Leave ________Hours

Comments: ____

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If receiving Short-Term Disability or Long-Term Disability on Federal FMLA, you are not required to use Vacation, Compensatory Time, or Sick Leave in conjunction with FMLA to supplement the 60% paid disability benefit to be made whole to 100%. However, it is your option to use this time to supplement any disability benefit. Will you be choosing to supplement with

❒Vacation ________Hours

❒Compensatory Time ________Hours

❒Sick Leave _______ _Hours

❒ I will be on STD and will not be supplementing with vacation/sick time

❒I will be on LTD and will not be supplementing with vacation/sick time

I understand and agree to the following provisions:

- ❑ I have read the ________ County policy on administration of the "Family and Medical Leave Acts".
- ❑ I will be financially responsible for my share of monthly medical insurance premiums, if any, and will ensure they are paid promptly as stated in the "Employer Response".
  - ❑ N/A
- ❑ I may be required to exhaust my paid vacation, sick leave or accumulated compensatory time off during my leave.
- ❑ I will be considered to have terminated my employment with ______ County if I do not return to work or contact my supervisor on or before the intended ending date of my leave.
- ❑ I understand that any misrepresentation by me in completing this form may subject me to discipline up to and including termination of my employment and I hereby attest to the truthfulness and accuracy of the above information.

____ ____________________________

Employee Signature Date

SUPERVISOR'S APPROVAL OF LEAVE REQUEST

❒ I hereby approve the request subject to verification of eligibility.

❒ I hereby deny this request for leave for the following reason(s):

____

____

____ ____________________________

Supervisor Signature Date

APPROVE OR DENY THIS REQUEST AND DELIVER OR FAX THIS DOCUMENT TO THE _______COUNTY DEPARTMENT OF ADMINISTRATION IMMEDIATELY AFTER RECEIPT FROM THE EMPLOYEE.