FAMILY AND MEDICAL LEAVE (FMLA) - <u>Request Form</u>

EMAIL request to: **FMLA@billingsmt.gov**

<mark>Thirty (30) days' notice is required when the need for leave is foreseeable.</mark>
<mark>When advance notice is not possible, the employee must provide the notice as soon as practical, typically within two (2) business days.</mark>

Employee Name: _____   Primary telephone #:_____

Personal Email address (*required for FMLA correspondence*): _____

Employed with the City more than one year?   Yes   No   Department: _____

Department Supervisor: _____ Have you informed them of your FMLA Request?   Yes   No

Estimated LEAVE BEGIN DATE: _____   **Estimated Release back to work DATE:** _____

Reason & Type of FMLA LEAVE Requesting

<u>EMPLOYEE</u> → Certification form required*: WH-380-E Certification of Health Care Provider for Employee's Serious Health Condition*

Your own serious health condition that makes you unable to work due to:

Medical procedure/In-patient hospitalization   Continuous treatment by a health care provider   Chronic condition

Employee TYPE OF LEAVE: Continuous block of time   Intermittent

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<u>FAMILY MEMBER</u> → Certification form*: WH-380-F Certification of Health Care Provider for Family Member's Serious Health Condition*   *The city does not require certification for Birth of child. FMLA starts with the baby's birth. If you need to go out prior to birth, then medical certification is required.*

The birth of a child*, or placement of a child with you for adoption/foster care, and to bond with the newborn/newly placed child.

TYPE OF LEAVE for birth/bonding: Per FMLA, a continuous block of time off for the birth is approved. If intermittent time away after the birth is requested, the employee must provide a reason for an intermittent schedule, subject to approval by HR and your Department.

TYPE OF LEAVE: Continuous block of time   Intermittent – *Required to provide proposed schedule and reason for intermittent working schedule for approval in writing.*

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<u>FAMILY MEMBER</u> → Certification form required: *WH-380-F Certification of Health Care Provider for Family Member's Serious Health Condition*

To care for your family member due to a serious health condition. Your family member is your:

Spouse   Mother   Father   Child under age 18   Child 18+ yrs. & incapable of self-care because of a mental or physical disability

TYPE OF LEAVE: Continuous block of time   Intermittent

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<u>MILITARY</u>

A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active-duty status. Your family member on covered active duty is your:

Spouse   Parent   Child of any age

→ Certification form required: WH-384 Certification of Qualifying Exigency for Military Family Leave

To care for your family member who is a covered service member with a serious injury or illness.

You are the service member's: Spouse   Mother   Father   Child

→ Certification form required: *WH-385 Certification for Serious Injury or Illness of Current Service member -- for Military Family Leave*
→ Certification form required: WH-385-V Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

Certification forms & FMLA items are available on the public city website: https://billingsmt.gov/417/Forms-and-Resources

ACKNOWLEDGEMENT by Employee:

I acknowledge the above FMLA Request, and that I have read the FMLA Notice to Employees. I also acknowledge the FMLA request is not valid until Human Resources approves it, which will be emailed to me with the approval details. I also acknowledge, it is my responsibility to provide the required medical certification timely and will communicate via email any status changes in my FMLA leave and Return to Work date. Lastly, it is my responsibility to code my approved time off as FMLA for payroll.

Employee Signature: _____   Date of Request: _____