UNION COUNTY
FAMILY MEDICAL LEAVE (FML) REQUEST FORM

Last Name: _____ **First Name:** _____ **MI:** __ **Employee ID #:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Area/Division: _____ **Supervisor:** _____

PURPOSE OF LEAVE (check one)

☐ **Employee's Personal Health Condition** _____
Please describe.

☐ An Occupational Injury or Disease covered by the North Carolina Worker's Compensation Act

☐ **The birth of a child, or placement of a child with you for adoption or foster care;**

☐ **Because you are needed to care for your due to his/her serious health condition.**

☐ **Because of a qualifying exigency arising out of the fact that your s on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.**

☐ **Because you are the of a covered servicemember with a serious injury or illness.**

FML Beginning Date: _____ **FML Ending Date:** _____

TYPE OF LEAVE TO BE USED DURING FML (check all that apply)

☐ **Sick Leave**, if available, **must be taken concurrently** during the FML period for personal illness. All sick leave accrued with Union County must be exhausted. UCPR Article VI, Section 6.8

☐ **Vacation Leave** or accrued **Holiday Leave** may be taken **concurrently** for any period of FML after all accrued sick leave has been exhausted.

☐ Leave is to be taken **intermittently**.

I certify that the information above is accurate. I understand that I will need to provide necessary medical documentation for any period of FML requested and that I will need to notify my division and/or Human Resources **immediately** if any information above should change.

EMPLOYEE: _____ **Date:** _____

As the supervisor of the employee listed above, I am aware that the employee has applied for Family Medical Leave. I understand that any paid leave taken **must also be posted concurrently against FML entitlement**. I will notify Human Resources **immediately** if I become aware of any changes to the information above.

SUPERVISOR: _____ **Date:** _____