State of Utah
Department of Human Resource Management

APPLICATION FOR FAMILY AND MEDICAL LEAVE

Employee Name: _____Dept: _____EIN: _____
Work Address: _____Work Phone: _____
Home Address:_____ Home Phone: _____
Proposed Start Date of Leave: _____Projected End Date of Leave: _____
(Mark approximate dates, not to exceed a total of 480 hrs. 12 wks. or 26 wks. as service member caregiver.)
Is leave being requested as intermittent? Yes___ No___
Is this application 30 days prior to the beginning of leave? Yes___ No___
Reason for Leave:_____
Is this requested leave for a reason FMLA leave was previously taken or certified? Yes___ No___
It is my intent to return to work. Yes ___ No___
I intend to use my own leave at the same time as my FMLA leave Yes__No__. If no, I intend to use Leave Without Pay__

Approval is contingent upon receipt of the Certification of Health Care Provider, which should be returned directly to the human resource office. All FMLA qualifying leave used will be counted against the maximum hours allowed. It is your responsibility to coordinate all leave with your supervisor.

Should you go into a leave without pay status while on FMLA leave, the Department will continue to pay only its share of your medical, dental, and life insurance benefits under the same conditions as before you went on leave without pay. You continue to be responsible for your share of medical, dental and life insurance premiums. Current benefits will continue unless you inform us you do not wish to retain these benefits. If the FMLA leave is taken without pay (LWOP), you shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

You must make every attempt to notify the Department at least two (2) working days in advance of the date of your intent to return from leave. Failure to return to work at the end of the designated leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by agency management. If you are medically able to return to work but elect not to, you may be required to reimburse all health and life insurance plan payments made by the State of Utah during your leave. Upon returning to work, every attempt will be made to restore you to your original position. If your original position is unavailable, you will be placed in an equivalent position with equivalent pay and benefits.

You may be required to sign a HIPPA release to obtain the medical clarification necessary when eligibility may be in question. Failure to provide sufficient information for certification or allow necessary clarification may result in the denial of Family and Medical leave.

Employee's Acknowledgement and Agreement _____
(Employee Signature)
Date of Application: _____Supervisor's Name _____

***** All Information Must be Complete and Signatures Obtained Before DHRM Approval *****

This Section for DHRM Use Only

12 months employment? (circle one): Yes No Verifier's Signature: _____
1250 hours **worked** in past 12 months? (circle one): Yes No Date: _____
If FMLA is for "Qualifying Exigency" of a spouse, child, or parent or for a "service member" caregiver, was the appropriate documentation provided? Yes No
(If "No" is circled on any line in this box, the employee is not eligible for FMLA leave.)
FMLA Hours Available: _____ *(thru the end of the current year) calendar___ or 12 month period___*

Approval Authority Signature: _____ Date: _____