

FAMILY AND MEDICAL LEAVE (FMLA) REQUEST

Pennsylvania Conference of Seventh-day Adventists

Office of the Secretariat

720 Museum Rd

Reading, PA 19611

Employee Name _____

Date of Hire _____

Department and Job Title _____

Work Location _____

I have not taken a leave of absence in the past twelve (12) months

I have taken a leave of absence in the past twelve (12) months

I request a leave of absence for the following reason:

To care for my child who was born on or is due on _____

Because I am adopting a child who will be placed with me on _____

Because a child is being placed with me for foster care beginning on _____

To care for my spouse, child, or parent who has a serious health condition that began on _____. Provide a brief explanation. The attached medical certification form will be required: _____

Because of my own serious health condition that began on _____ and that renders me unable to perform the functions of my job. Provide a brief explanation. The attached medical certification form will be required: _____

Qualifying exigency for military persons or his/her qualified family member. Provide a brief explanation. The attached medical certification form will be required: _____

If FMLA leave is requested for care of a family member, provide the following information:

Name of family member: _____

Relationship of family member to you: _____

Will the requested leave will be on an intermittent or reduced work schedule basis? If yes, I understand that I will need to work with my supervisor to arrange a mutually acceptable schedule for intermittent or reduced work schedule.

Yes No

Date FMLA is to begin _____ Duration _____

Date FMLA is to end _____ Return to work _____

Number of days of unused vacation time prior to leave _____

Contact Information while on leave:

Phone _____ Email _____

Address _____

I understand and will comply with the following conditions:

1. I understand that if I have accrued paid leave under any other paid leaves of absence policies that I will be required to use paid leaves first and take the remainder, if any, of the requested leave as unpaid.
2. I understand that this request for leave is to be submitted, for foreseeable leave circumstances, to the Pennsylvania Conference Office of the Secretariat, Human Resource Department a minimum of 30 days before requested leave. Should this not be possible, I understand that I must discuss my request for leave with my supervisor and the Human Resource Department designee in as timely a manner as possible. I further agree to submit, when necessary, a completed Certification of Physician or Practitioner Form to the Human Resource Department a minimum of 15 days before requested leave for foreseeable leave circumstances, or provide an acceptable explanation for the delay.
3. I understand that I may be required to periodically report to my supervisor or the Human Resource designee the status of my leave. I also agree that I will need to obtain a job-related "fitness for duty" certificate from the attending physician or health care provider prior to my return to work if my Family and Medical Leave was based on my personal serious health condition.
4. I understand that the Pennsylvania Conference will continue my employee benefits during the approved leave period at the same level and under the same conditions as if I had continued to work. If I am paying monthly premiums for any insurances, these costs will be deducted during any paid leave and recovered when the unpaid leave is ended. If I do not return to work after the leave, any unpaid premiums will be due and payable to the Conference.
5. I understand that I will not accrue service credit benefit based upon length of service beyond the last paid day prior to the start of the unpaid leave of absence.

Date of Request

Employee Signature

Date

Supervisor Signature

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Date Request Received _____

ADCOM Item Number _____

Approve with leave effective _____

Deny due to _____

CERTIFICATION OF PHYSICIAN
OR PRACTITIONER

(Family and Medical Leave Act of 1993)

1. Employee's Name	2. Patient's Name (if other than employee) and Relationship to Employee
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3. Diagnosis _____

4. Date Condition Commenced	5. Probable Duration of Condition
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6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment, if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)

a. By Physician or Practitioner

b. By another provider of health services, if referred by physician or practitioner.

If this certification relates to care for the employee's seriously-ill family member, skip Items 7, 8 and 9 and proceed to Items 13 through 20 on reverse side. Otherwise continue below.

7. Is in-patient hospitalization of the employee required? Yes No

8. Is employee able to perform work of any kind? (If "NO", skip Item 9) Yes No

9. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee). Yes No

10. Signature of Physician or Practitioner	11. Date	12. Type of Practice (Field of Specialization, if any)
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For certification relating to care for the employee's seriously-ill family member, complete Items 13 through 17 below as they apply to the family member and proceed to Item 20.

13. Is in-patient hospitalization of the family member (patient) required? Yes No
14. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? Yes No
15. After review of the employee's signed statement (See Item 17 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) Yes No
16. Estimate the period of time care is needed or the employee's presence would be beneficial.
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Item 17 is to be completed by the employee needing family leave.

17. When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which the care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

18. Employees Signature		19. Date
20. Signature of Physician or Practitioner	21. Date	22. Type of Practice (Field of Specialization, if any)