**Family Medical Leave Act**

**Request for Intermittent or Reduced-time Unpaid FMLA/SPF Absence**

**After 12 Weeks for a Catastrophic Illness/Injury**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Employee** | | | | |
| Employee | Personnel Number | | Telephone Number | |
|  |  | |  | |
| Agency | | Work Location | | |
|  | |  | | |
| Supervisor Name | | Timekeeper Name (optional) | | |
|  | |  | | |
| The intermittent or reduced-time FMLA/SPF absence will be used to cover absences from:   |  |  |  | | --- | --- | --- | | From Date | TO | To Date | |  |  | | | | | |
| Employee Signature | | | | Date |
| **Human Resources Office** | | | | |
| Date when **ALL** accrued and anticipated leave was exhausted: | | | | |
| Review and check the following statements:  In the past six-month period, the employee **has not**:   * been placed on a written leave restriction * received a written reprimand related to attendance * received a suspension related to attendance   The absences were not due to a work-related illness/injury.  I recommend:  Approval  Disapproval | | | | |
| Signature of HR Director or FMLA/SPF Coordinator | | | | Date |
| **OFFICE OF ADMINISTRATION** | | | | |
| Request is approved through the following date: \_\_\_\_\_\_\_\_\_\_\_  Request is denied because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Secretary of Administration Designee | | | | Date |
| ***Please return this form to***:      , FMLA/SPF Coordinator        **Phone:**       **Fax:**       **Email:** | | | | |