|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **INSTRUCTIONS** | | | | | | | | |
| Complete this form to request an absence in accordance with the Family and Medical Leave Act (FMLA). Consult with your FMLA/SPF Coordinator to determine eligibility. Supporting documentation is required within 15 calendar days. FMLA/SPF absence cannot be used for approved work-related injuries. Reference the *Notice to Employees* for additional information. **Changes to leave elections must be made on a subsequent *Request for FMLA/SPF Absence* form and will be applied to absences prospectively.** | | | | | | | | |
| **EMPLOYEE INFORMATION** | | | | | | | | |
| Employee Name | | Personnel Number | | Agency/Work Location | | | | |
|  | |  | |  | | | | |
| Supervisor Name | | Preferred Telephone Number (Optional) | | | | Preferred E-mail Address (Optional) | | |
|  | |  | | | |  | | |
| **REASON FOR ABSENCE (check one)** | | | | | | | | |
| My Own Serious Health Condition (*Employee Serious Health Condition Certification* is required)  To Care for a Family Member (*Family Member Serious Health Condition Certification* is required) | | | | | | | | |
|  | Name of Family Member | | Relationship | | Age (if child)\* | | |  |
|  |  | |  | |  | | |  |
| \*NOTE: For child 18 years or older, the *Adult Child Certification of Disability* is required  For the Birth, Adoption, or Foster Care Placement (proof of birth, adoption, or foster care placement is required) | | | | | | | | |
| **AMOUNT OF LEAVE NEEDED (check all that apply; use estimated date if actual dates are unknown)** | | | | | | | | |
| Full-time absence from       through  Intermittent absences from       through  *(sporadic absences, may be unpredictable in nature)*  Reduced-time absences from       through  *(set, recurring absence, e.g., work 4 hours per day or off every Monday. For reduced-time absences due to the birth, adoption, or foster care placement of a child, approval will be consistent with operational needs; please discuss the work times with your supervisor prior to request.)*  Proposed Reduced-time Schedule: | | | | | | | | |
|  | | | | | | | | |
| **LEAVE ELECTIONS (check all that apply)** | | | | | | | | |
| The use ofall applicable accrued (actual) sick leave is mandatory and automatically applied for absence reasons that sick leave is ordinarily used before any other *optional* paid absence type is applied. For full-time absences, leave will be applied in the order listed below unless you provide other instructions in the space provided below.   |  |  | | --- | --- | | **Accrued (Actual) Leave**  Sick (YS)/Sick Family (YSF)/Additional Sick Family (YSC)  Annual (YA)  Combined (YC)  Personal (YP)  Holiday (YH)  Compensatory (YCMP) | **Anticipated Leave\*\***  Sick (YS)/Sick Family (YSF)  Annual (YA)  Combined (YC)  Personal (YP) |   **If no leave election boxes are checked, unpaid leave will automatically be applied after all applicable sick leave is exhausted.**  Unpaid Leave (YUSO, YUPO or YUFO)  \*\* NOTE: If you elect anticipated leave and then commence unpaid FMLA/SPF Absence, it will result in a negative anticipated leave quota. Additionally, if you separate from employment, it will result in a debt that will need to be recouped. | | | | | | | | |
| **SPECIAL INSTRUCTIONS FOR USING LEAVE** | | | | | | | | |
| Please save     accrued/actual sick days (10 days maximum, if permitted in collective bargaining agreement) \*\*\*  \*\*\*NOTE: If elected, you cannot use anticipated sick leave. | | | | | | | | |
| **ACKNOWLEDGEMENT - I have read and understand the information and leave elections on this form.** | | | | | | | | |
| Signature | | | | | | | Date | |
|  | | | | | | |  | |
| **RETURN COMPLETED FORM TO** | | | | | | | | |
| **[NAME], FMLA/SPF Coordinator, [AGENCY]**  **[ADDRESS]**  **Phone: [XXX.XXX.XXXX] Fax: [XXX.XXX.XXXX] E-mail: [USERID@pa.gov]** | | | | | | | | |