**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:**       |