pennsylvania

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 Date
	TO	

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 Specialist
HR Service Center - FMLA
PO Box 824
Harrisburg, PA 17108-0824

Phone: 717.346.4667 Fax: 717.425.5389 Email: RA-SPFabsence@pa.gov

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