ASPIRUS
Passion for excellence. Compassion for people.

LEAVE MANAGEMENT SERVICES

FAMILY MEDICAL LEAVE (FMLA) REQUEST FORM

1. Employee Name	2. Date of Birth	3. Employee Number
4. Employee Address City State Zip		5. Phone Number ( )
6. Employer Name	7. Job Title	8. FTE Status

Type of Leave:

☐ Due to the birth of a child, or placement of a child with you for adoption or foster care.

☐ Due to a serious health condition for:
☐ self ☐ spouse ☐ parent ☐ child; ☐ parent-in-law (WI only) ☐ domestic partner (WI only)
Name of the person you will be caring for: _____

☐ Due to a qualifying exigency arising out of the fact that your:
☐ spouse ☐ son or daughter ☐ parent: is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

☐ Due to you being the:
☐ spouse ☐ son or daughter ☐ parent ☐ next of kin: of a covered service member with a serious injury or illness.

9. Leave Start Date	10. Leave End Date
11. Briefly explain reason for leave request	

12. If you are eligible for FMLA coverage only, do you wish for your time to be:

☐ Unpaid time ☐ Paid with PTO, Amount of PTO to be used per week _____

****Please Note:** Your organization's FMLA policy may require the use of available PTO hours during the waiting period for Short Term Disability benefits or during FMLA designated time.

13. How would you like to be contacted by Leave Management Services throughout the duration of your leave?

☐ Home address ☐ Home email ☐ Work email

If by home email, please indicate your home email address: _____

**At the end of your leave, you will be asked to complete a customer satisfaction survey. Your feedback is important to us! The survey will be sent to you by the method in which you have indicated above.*

Employee Signature: _____ Date: _____