



City of Pittsburgh Request for Family/Medical Leave

To Be Completed by Employee:		
Employee's Name:	Department:	Date of Request:
Job Title:	Employee #:	Hire Date:
Mailing Address:		Phone:
Reason for Leave of Absence <input type="checkbox"/> Own serious illness (not work related) <input type="checkbox"/> Care for ill parent, spouse or domestic partner, or child <input type="checkbox"/> Birth of a child/care of such child <input type="checkbox"/> Placement of a child for adoption/foster care <input type="checkbox"/> To assist a child, spouse, or parent who is a member of the Armed Forces, including National Guard or Reserves, with a "Qualifying Exigency" related to covered active duty or a call of active duty status. <input type="checkbox"/> To care for a child, spouse, parent or "next of kin" covered service member of the United States Armed Forces who has a serious injury or illness incurred or aggravated in the line of duty while on active duty (up to 26 weeks leave).		
Please Initial the Following Terms:		
	I understand that I am required to submit the applicable <i>Physician or Practitioner note</i> to Human Resources within 15 days of submitting this Request for FMLA to my supervisor. If I'm unable to obtain medical certification within 15 days of my request, I will contact Human Resources before my leave begins.	
	I understand that if my leave is approved, any time away from work for this event will be charged against my 12-week leave maximum under Family/Medical Leave.	
Method Of Leave Requested:		
<input type="checkbox"/> Consecutive leave <input type="checkbox"/> Intermittent or reduced schedule (specify schedule below)		
Date leave is to begin:	Anticipated end date:	
Use of Accruals While on FMLA:		
You have the right to substitute sick, vacation, and/or other paid accruals for your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid leave. <u>Please designate paid accruals to be used i.e. sick, comp time, vacation, other while on leave.</u> Human Resources will complete your timesheet.		
1 st _____ 2 nd _____ 3 rd _____ 4 th _____		
If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks OR 26 weeks to care for an injured service member, I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks OR 26 weeks to care for an injured service member, I will be returned to my same or equivalent position, only if available. Refer to Family Medical Leave Personnel Rule for additional information or contact Human Resources.		
Employee Signature:		Date:
Authorization for approval:		Date:
Department Supervisor:		
Department Director:		
Human Resources:		