

Pulaski County
EMPLOYEE APPLICATION FOR LEAVE OF ABSENCE
Family Medical Leave Act (FMLA)

Name _____ Date of Application _____

Department _____ Immediate Supervisor _____

Type of Leave Requested: Family Medical Family and Medical

Leave to begin (first day) _____ Expected Return Date _____

Leave under the Family Medical Leave Act (FMLA) is unpaid. However accrued sick and vacation hours will be used for paid leave. This is not an option.

Reason for Leave Request: (Provide a full explanation – use additional sheets as needed)

Note: As your employer, Pulaski County requires a medical certification that leave is needed due to the employee’s own serious health condition or that of a family member. A sufficient certification to support your request must be provided in a timely manner for you to be approved. The County may, at its expense, require a second medical opinion. If the first and second opinions differ, the County may, at its expense, request a third opinion. The third opinion is binding.

I, _____ understand that if I do not return from my leave of
 Employee's name
absence, unless an extension has been approved in advance, my employment may be terminated.

Employee's Signature _____

Date _____

Supervisor's Signature _____

Date _____