



City of Helena

Employee Family & Medical Leave Request Form

Instructions for the Employee

- Complete the form and submit to HR. If you have questions call 447-8333 or 447-8404.
- You will be notified as to whether the leave is approved or not or if additional information is needed

EMPLOYEE INFORMATION

Employee Name: _____

Department: _____

TYPE OF LEAVE - I hereby request the following type of leave:

Family leave for the:

Birth of my son or daughter

Placement of a child with me for

adoption

foster care

Anticipated date of birth or placement: _____

Family leave to care for a spouse, son, daughter, or parent with a serious health condition

Family member's full name:

Relationship to you: spouse

parent

son or daughter other (if applicable)

Medical leave for my own serious health condition (specify): _____

AMOUNT OF LEAVE

(1) I request that the leave be granted for the following period of time:

Beginning on (date): _____ Ending on (date): _____

(2) I further request that the leave be granted for the following reduced or intermittent leave schedule:

(3) I would like to substitute the following paid leave time, if applicable, during my family or medical leave:

sick vacation other: _____

(4) Donated Sick leave – follow Personnel Policy – See Section 81-2a – Must meet criteria

EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and will subject me to discipline up to and including termination.

Signature: _____

Date: _____

MAINTAIN THIS FORM IN A FMLA CONFIDENTIAL FILE FOR HR USE ONLY

Leave Approved: Yes No Beginning date: _____ Expected Return Date: _____

The following paid leave will be substituted: _____

Insurance premium to be paid as follows:

Remarks _____

Signature of HR: _____ Title: _____ Date: _____