Family or Medical Leave Request

NOTE: Requests for family or medical leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

Employee Name: ____

Worksite: ____

Date: ____

I am requesting a family or medical leave for one or more of the following reasons:

❑ Because of the birth of my child, or the placement of a child for adoption or foster care.
For Approval, Complete FMLA Certification of Health Care Provider for Employee's Serious Health Condition

❑ In order to care for my spouse, child, or parent, who has serious health condition.
For Approval, Complete FMLA Certification of Health Care Provider for Family Member's Serious Health Condition

❑ For a serious health condition that makes me unable to perform my job. Please describe below:
For Approval, Complete FMLA Certification of Health Care Provider for Employee's Serious Health Condition

❑ Because of a qualifying exigency arising out of the fact that your spouse, child or 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.
For Approval, Complete FMLA Certification of Qualifying Exigency for Military Family Leave

❑ Because you are the spouse, child, or parent of a covered service member with a serious injury or illness. Please describe below. *For Approval, Complete FMLA Certification for Serious Injury or Illness of a Current Servicemember – for Military Family Leave*

❑ In order to care for a child whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19**.** ***For Approval, submit documentation from the child's school or place of care stating that they are closed for reasons related to COVID-19 along with this request form. Further, my signature below is my confirmation that I am unable to work or telework during this period of time and that no other suitable person is available to provide care for my child(ren).***

Child's name:___________________________________ Child's Date of Birth*: ____________________

Child's school/place of care: ______________________ Child's grade in school: __________________

Requested leave start date: ___________________________ Anticipated return date: ___________________________

❑ Proposed intermittent leave schedule, if applicable will be subject to supervisor/employer's approval:

Have you taken any family or medical leave in the past 12 months ? ❑ Yes ❑ No. If yes, for how long? ____________________

Signature

I understand that I am entitled to up to 12 weeks of leave for the purpose of birth, adoption or placement of a foster child, or to care for a sick spouse, child, parent, or because of my own serious illness. I certify that all information contained in this request is true and that omission, falsification, or misrepresentation of any material contained herein are grounds for immediate termination. I further understand that in the event I do not return to work at the end of the 12 week period, I will be terminated. In addition, I understand that if I choose not to return to work for personal reasons, I will owe the Company the cost of all health insurance premiums paid on my behalf during my leave.

Signature____ Date________________________

Please fax or mail this request to:
Synergy
Attn: FMLA
230 W Monroe, Suite 2400
Chicago, IL 60606
Fax: 312-977-9039
Phone: 800-432-1026