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| DOTLOGOMISSOURI DEPARTMENT OF TRANSPORTATIONNOTICE OF NEEDFAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE |

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| Name: |       |
| Home Address: |       |
| Home Phone Number: |       |
| Job Title: |       |
| District/Division/Office: |       |
| Supervisor: |       |

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| I have reviewed Personnel Policy 3512, “Family and Medical Leave” to determine my eligibility and am now requesting leave under the FMLA for: |
| [ ]  | the birth of my child |
| * expected due date:
 |       |
| [ ]  | the placement (adoption or foster care) of a child with me |
| * expected placement date:
 |       |
| [ ]  | my serious health condition (including incapacity due to pregnancy, prenatal medical care, childbirth) |
| * describe:
 |       |
| [ ]  | the care of my spouse/child/parent with a serious health condition |
| * describe:
 |       |
| [ ]  | the qualifying exigency arising out of the fact that my spouse/child/parent is a member of the Armed Forces on covered active duty or call to covered active duty status  |
| * describe:
 |       |
| [ ]  | the care of an injured/ill servicemember for whom I am the spouse/child/parent/next of kin |
| * describe:
 |       |

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| Expected start date of leave: |       |
| Expected date of return to work: |       |

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| The type of leave I plan to use to cover this absence\* (check all that apply and rank in order) |
| [ ]  | Parental leave | [ ]  use all  | [ ]  use |       | hours | Apply [ ] 1st [ ] 2nd [ ] 3rd [ ] 4th  |
| [ ]  | Paid sick leave | [ ]  use all  | [ ]  use |       | hours | Apply [ ] 1st [ ] 2nd [ ] 3rd [ ] 4th  |
| [ ]  | Paid annual leave | [ ]  use all  | [ ]  use |       | hours | Apply [ ] 1st [ ] 2nd [ ] 3rd [ ] 4th |
| [ ]  | Compensatory time | [ ]  use all  | [ ]  use |       | hours | Apply [ ] 1st [ ] 2nd [ ] 3rd [ ] 4th |
| [ ]  | Unpaid FMLA leave | [ ]  use all  | [ ]  use |       | hours | Apply [ ] 1st [ ] 2nd [ ] 3rd [ ] 4th |

\*Please refer to leave usage policies to determine which types of leave are appropriate for this absence.

 Note that you may be required to exhaust paid sick leave prior to taking unpaid FMLA leave.

 Rank the types of leave in the order you would like them applied to cover your period of absence.

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| Employee Name: |       |  |

In requesting this FMLA leave, I understand the following:

1. When requested, I must provide certification describing the details that make my condition a qualifying event under the FMLA, within the required time frame.
2. If I am requesting leave for my own serious health condition, to care for my family member with a serious health condition, or to care for an injured/ill servicemember, I must first exhaust my accrued paid sick leave before taking unpaid FMLA leave (unless the servicemember being cared for does not fall under the department’s sick leave policy definition of immediate family and sick leave cannot be used).
3. I have the right, but will not be required to, use other accrued paid leave before taking unpaid FMLA leave. If approved, all unpaid leave I take for the reason designated on this form is being/will be designated by the department as FMLA leave and will count toward my FMLA leave entitlement.
4. While I am on unpaid FMLA leave, the department will continue to provide its share of premiums for health insurance coverage; however, I am responsible for manually making my share of premium payments during this time. State sponsored life insurance and disability insurance coverage provided to me at no cost is not included in the department's share of health insurance coverage provided to employees on unpaid FMLA leave. I have the option of continuing coveragefor health, life, or disability insurance by making manual payments during my approved FMLA leave. If my premium payments are not made on or before the due date, coverage may lapse.
5. I may be required to furnish periodic reports of my status and intent to return to work.
6. Prior to returning to work from leave for my own serious health condition, I will be required to provide a certification from my health care provider indicating whether I am able to return to full duty or with restrictions. I will not be allowed to return to work until the department receives a completed certification from my treating physician.
7. I will be restored to the same or an equivalent job upon return from FMLA leave.
8. Failure to return to work at the end of my approved leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the department.
9. If I fail to return to work after taking FMLA leave, I may be required to reimburse health insurance premiums paid by the department on my behalf while I was on unpaid FMLA leave.

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| Supervisor Signature: |  | Date: |  |

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| Employee Signature: |  | Date: |  |

Both the employee and the supervisor should sign and date this form and retain a copy for their records. This form should then be forwarded to your local human resources representative. Please refer to Personnel Policy 3512, “Family and Medical Leave,” for further information about FMLA leave.

NOTE: The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.