SEDGWICK COUNTY
FAMILY MEDICAL LEAVE (FML)
REQUEST FOR LEAVE

Return forms to: Fax: 316-941-5132
Email: FMLA@sedgwick.gov

TO BE COMPLETED BY EMPLOYEE

Employee Name _____ EE# _____ Cell# _____
First Middle Last

Home Address_____
Mailing/Street Address City State Zip

Department/Division: _____

If your spouse is a County employee, provide
His/Her Name: _____

Home Email_____
(Please provide a non County email address you can access while on FML)

Spouse's Department: _____

I am requesting: ☐ Intermittent FML (various days/times-unscheduled) ☐ Continuous FML (pre-scheduled)

Intermittent requests are valid for six (6) months. Requests must be submitted at least 30 days in advance of scheduled treatments.

Reason requesting Family Medical Leave (check one):

☐ Your own serious health condition.

☐ The birth of a child, bonding with a child or the placement of a child with you for adoption or foster care.

☐ You need to care for your: ☐ spouse; ☐ child under 18; ☐ child over 18 (documentation required);
☐ parent due to his/her serious health condition.

☐ A qualifying exigency arising out of the fact that your ☐ spouse; ☐ child; ☐ 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.

☐ You are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered service member with a serious injury or illness. (Active Duty)

☐ You are providing care for a U.S. Veteran.* Please list your relationship: _____
No biological or legal relationship is necessary. "Next of kin" is the veteran's nearest blood relative, other than the spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative as designated in writing by the veteran for purposes of FMLA leave, (2) blood relatives granted legal custody of the veteran, (3) brothers and sisters, (4)grandparents, (5) aunts and uncles, and (6) first cousins.

Expected leave begin date: _____

Expected return to work date: _____ (Intermittent leaves are valid for 6 months)

Sedgwick County requires an employee seeking FMLA leave to submit the appropriate Certification of Health Care Provider form within 15 calendar days. Employees seeking leave for the placement of a child for adoption or foster care must provide proper documentation within 15 calendar days of request.

Employees seeking to return to work must notify their department forty-eight (48) hours prior to their date of return and submit a completed Return to Work Certification Form to Human Resources upon their return before they are allowed to resume work. Please utilize your department's normal call-in procedures and inform your immediate supervisor of your availability for work.

I understand that I may not be permitted to resume my position with Sedgwick County unless I notify my department forty-eight (48) hours prior to my date of return and provide a completed Return to Work Form to Human Resources upon my return to work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse Sedgwick County for the cost of health benefits provided by Sedgwick County during my leave, unless I fail to return to work because of my continued serious health condition, or other circumstances beyond my control.

I authorize a Sedgwick County representative to contact my health care provider to authenticate and clarify any information provided on the Certification of Health Care Provider form under the Family Medical Leave Act unless otherwise indicated in the check boxes below.

☐ **Yes,** I authorize a Sedgwick County representative to contact my health care provider to authenticate and clarify any information provided on the Certification of Health Care Provider form

☐ **No,** I do not authorize a Sedgwick County representative to contact my health care provider to authenticate and clarify any information provided on the Certification of Health Care Provider form

Employee Signature_____ **Date**_____

SUBMIT