

Johns Hopkins Health System Corporation/The Johns Hopkins Hospital
REQUEST FOR FAMILY AND MEDICAL LEAVE (FMLA)

PART A – EMPLOYEE INFORMATION

NOTE: Your supervisor must sign the form before completion by your Health Care Provider.

Employee Name _____ Social Security # _____

Home Address _____ Zip _____

Home Phone _____ Work Extension _____

Job Title _____ Department Name _____

Employee's E-mail Address _____

Please check box, if you wish to receive your FMLA approval/denial notification by e-mail rather than a letter via mail.

Date FMLA Leave to Commence _____

(30 days advance notice required for foreseeable leave or if not foreseeable leave then medical certification must be received within 15 days of taking FMLA Leave)

Duration: Intermittent _____ Weeks
(not to exceed 12 weeks in a rolling calendar year)

Reason for Leave: (Please check all that apply. If it's for your own illness or of a family member, a Certification of Health Care Provider Form must be completed and returned with this form):

Illness Injury Surgery Maternity (Paternity) Leave

Dependent: _____ (specify dependent and relationship)

I have read the section entitled "Your Rights" under the Family and Medical Leave Act 1993 attached to this form.

Employee Signature _____ Date _____

PART B – SUPERVISOR'S INFORMATION

Note: The employee should take this form and the attached Certification of Health Care Provider to their health care provider before submitting it to the HR Service Center for review. You will receive a copy of the approval/disapproval from the HR Service Center once the certification has been reviewed. Please note the employee is not obligated to detail the medical diagnosis on this form since it must be included on the Certification completed by the health care provider.

Supervisor's Name, Extension, and Location _____

Supervisor's E-mail Address: _____ Date _____

Supervisor/Manager Signature: _____ Functional Unit _____ Cost Center _____

PART C – HUMAN RESOURCES

____ Approved _____ Disapproved _____ Reason: _____
Signature _____ Date _____

PLEASE RETURN THIS FORM TO HR