



**Family and Medical Leave Act
(FMLA) Leave Request**

Employee Name: _____ Employee #: _____

Requested Leave Start Date: _____

Estimated Leave End Date: _____

Reason for FMLA Leave Request (select the situation that applies):

- _____ Your own serious health condition
- _____ The birth of a child, or placement of a child with you for adoption or foster care
- _____ You need to care for your family member due to his/her serious health condition:
 - _____ Spouse
 - _____ Child
 - _____ Parent
- _____ A qualifying exigency arising out of the fact that your spouse, son or daughter, or parent is on covered active duty or call to covered active duty status with the Armed Forces.
- _____ You are the spouse, son or daughter, parent, or next of kin of a covered servicemember with a serious injury or illness.

Leave is expected to be (select the type that applies):

- _____ For a continuous block of time (several continuous days, weeks, or months)
- _____ For a reduced work schedule (change in work scheduled needed; fewer hours per day or fewer hours per week).
- _____ On an intermittent basis (periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups of a medical condition and/or for ongoing medical treatment/appointments).

Signature of Employee

Date

Please return completed form to: Tyler Jarl, Human Resources Manager – Benefits

Email: tjarl@roundrocktexas.gov

Fax #: 512-682-8766