Polk State College
Family Medical Leave Act
LEAVE REQUEST

Employee Name: _____ PID: _____

Department: _____

I would like to request _____ days of leave under the Family and Medical Leave Act (FMLA) of 1993.

Check the appropriate line:

_____ 1. For the birth or placement of a child for adoption or foster care.

_____ 2. To care for an immediate family member (spouse, child or parent) with a serious health condition.

Family member name:_____

Relationship:_____
(Note: Complete Medical Certification Form)

_____ 3. To take medical leave when the employee is unable to work because of a serious health condition.
(Note: Complete Medical Certification Form)

Date FMLA leave will start: _____

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

_____ _____
Department Head Signature Date

_____ _____
Appropriate President's Staff Members' Signature Date