COMMONWEALTH OF MASSACHUSETTS

EMPLOYEE NOTICE OF FAMILY OR MEDICAL LEAVE

DIRECTIONS TO EMPLOYEE:

1. You may use this form to **notify management** of your anticipated date of FMLA leave.

2. Please fill out this form and return it to your supervisor **30 days prior** to your anticipated leave date, or if your leave is unforeseeable, as soon as practicable.

TO BE COMPLETED BY EMPLOYEE: (please print or type)

1. Employee's Name Employee ID

   Department / Agency

2. Patient's Name (If other than employee)

   Relationship to Employee

3. Employee's Current Address

4. Type of FMLA Leave Requested:

   ☐ Consecutive Months (up to 26 weeks) Beginning Date Ending Date

   ☐ Intermittent Leave Expected days/weeks/months on leave

   ☐ Reduced Leave Schedule (specify change in schedule)

5. Reason for Leave:

   ☐ Birth of a child Estimated Date of Delivery

   ☐ Placement of a child by foster care or adoption Date of Placement

   ☐ Family member's "serious health condition"

   ☐ Employee's own "serious health condition"

6. I understand that the employer may request a verifying medical certification from a physician for a leave request based on my serious health condition or the serious health condition of my spouse, child, or parent and that the employer may require a second or third medical opinion (at the employer's expense) as well as periodic re-certification. **I hereby authorize a health care provider representing the employer to contact my physician to verify the reason for my requested family and medical leave.**

7. I understand that the employer may require a fitness-for-duty examination and certification to return from leave.

8. I understand that a failure to return to work at the end of the leave period may be treated as a resignation unless an extension of leave has been agreed upon and approved by the employer.

9. I understand that a failure to return to work at the end of the leave period may require me to reimburse the employer for its share of health insurance premiums paid on my behalf during the leave period.

Signature:_____ Date:_____

APPROVED BY:_____

Supervisor