



Request for a Foreseeable Family Medical Leave

Form A

To be completed by the employee

Submit completed form to the Department of Human Resources at **least 30 days in advance of the requested date** for starting absence. Include appropriate Certification of Health Care Provider form when the request is based on a serious personal health condition, the birth, adoption, or foster care placement of a child, or the care of a family member or a covered servicemember. Include Certification of Qualifying Exigency form for an absence due to a qualifying exigency.

Name (First, Middle Initial, Last) _____ Date of Request _____

Home Address _____ City _____ State _____ Zip _____

Employee ID Number _____ Home Phone _____

Work Location _____ Work Phone _____

Position _____ Full Time
 Part Time (specify) _____

1. Dates of Leave
Beginning Date of Absence _____ Date Sick Leave Begins _____
(Mandatory for own serious health condition or care of a family member; optional for child care)

Date Leave Without Pay Begins _____ Expected Return Date _____
(A maximum of 12 weeks per 12-month period from the beginning date of leave may be requested)

2. Application of Leave (check one and explain)
 a. Continuous A period of time without interruption
 b. Reduced schedule ... A less-than-regular work schedule established with specific days and reporting times
 c. Intermittent A period of time when the regular working schedule is periodically interrupted with brief periods of absence
(Teachers requesting b. or c. should refer to section IV.E of the current version of Regulation 4835)

Explanation of work plan based on the health care provider's statement

3. Reason for Leave Request (check one and explain)
 a. Serious personal health condition
 b. Birth or adoption of a child or placement of a foster child
 c. Care of a sick child, spouse, or parent **(choose one)**
 d. Care of an injured or ill active servicemember
 e. Management of exigencies (for National Guard and Reservists)

Explanation of the care to be provided and an estimate of the time period required, including a schedule, if leave is to be taken intermittently or on a reduced leave schedule

Employee's Signature _____ Date _____ Signature of Principal or Program Manager _____ Date _____

cc: Principal or Program Manager
Personnel Medical File Emp. ID# _____

Return this form to:
Department of Human Resources,
Office of Benefit Services, Disability and Leaves Section
8115 Gatehouse Road, Falls Church, VA 22042
FAX (571) 423-5013