CITY OF EL PASO, TEXAS
Human Resources Department

Request for Family or Medical Leave

NAME (Last, First, Middle Initial): (Type or Print in ink)	SOCIAL SECURITY #: (Last 6) XXX - -	KRONOS ID#
DEPARTMENT:	DATE:	

Start Date of Anticipated Leave _____/_____/_____

Expected Date of Return to Work: _____/_____/_____ ☐ Intermittent Leave

REASON FOR REQUEST:

☐ Birth or Placement of a Child for Adoption or Foster Care

Date of Birth/Placement _____/_____/_____

☐ Care for Immediate Family Member (Spouse, Child, or Parent) with a Serious Health Condition

Name: _____

Relationship: _____ If Child, Age:_____ DOB _____

☐ Employee's Serious Health Condition; ☐ Personal or ☐ Workers' Compensation – DOI: _____

Is Your Spouse a City Employee? ☐ Yes ☐ No

If Yes, Name: _____

Department Working In: _____

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

I hereby authorize the City of El Paso to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the City of El Paso.

EMPLOYEE'S SIGNATURE:	DATE:
SUPERVISOR'S SIGNATURE:	DATE:
DEPARTMENT HEAD'S SIGNATURE:	DATE:

IF APPLICABLE, CHECK BELOW:	SUPPORTING DOCUMENTATION ATTACHED:	DISTRIBUTION:
☐ Employee wants a copy of this form	☐ Physician's Certificate	Original – Human Resources
☐ Employee not available to sign this form	☐ Birth Certificate/Placement Papers	Copy – Department, Employee

TO BE COMPLETED BY HUMAN RESOURCES ONLY Date: _____ Initials: _____

☐ FMLA Letter: From: _____ To: _____

☐ Intermittent: From: _____ To: _____

☐ Tentative Approval Pending DOL Docs due by: _____ ☐ 15 Days Following Birth of Child

☐ Denied: _____

Notes: _____