CITY OF HIALEAH

Human Resources Department

Application for Family Medical Leave

Name: ______________________ Department: ______________________

Current Address: ______________________

Start Date of Anticipated Leave: ______________________

Expected Date of Return to Work: ______________________

Reason for Leave (Explain): ______________________

____

____

____

Eligibility: In general, an active employee is eligible for leave under the Family Medical Leave Act provided that:

1. You have been employed by the City of Hialeah for at least 12 months; and
2. You have worked for the City 1,250 hours or more in the 12-months period immediately preceding the commencement date of leave; and
3. You must not have taken twelve (12) weeks of leave under Family Medical Leave Act (FMLA) within the same calendar year as the commencement date of the requested leave.

Medical Certification: An employee requesting leave for the employee's serious health condition or to care for a family member with a serious health condition must submit written *Medical Certification of the need for such leave from the applicable health care provider*. In addition, while the employee is on leave, he/she will be required to provide periodic recertification of his/her medical condition.

If you expect to take family and medical leave, you must complete this form at least 30 days in advance of the expected leave and provide any required Medical Certification or supporting document.

I hereby authorize a representative of the Human Resources Department at the City of Hialeah to contact my physician to verify the reason or seek clarification for 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 voluntary resignation unless an extension has been agreed upon and approved by the City.

______________________ Date: ______________________

Employee Signature

RECEIVED BY:

______________________ Date: ______________________

Director of Human Resources or Designee