FTD Leave Management
Leave of Absence Application Form

TO BE COMPLETED BY EMPLOYEE

Employee Name (First, MI, Last) Employee ID:

Employee Phone Number Home: ( ) Work: ( )

Employee Home Email Address

Employee's Home Street Address	City	State	Zip

Reason for Leave

☐ Birth of a Child ☐ Baby Bonding ☐ Placement of a child with you for adoption or foster care

☐ A serious health condition that makes you unable to perform the essential functions of your job

☐ A serious health condition affecting your spouse, domestic partner, child or parent for whom you are needed to provide care

☐ For qualifying exigencies arising from your ☐ spouse, ☐ son or daughter, or ☐ parent being on active duty or called to active duty status as a member of the National Guard or Reserves in support of a contingency operation ☐ Military Leave

☐ Personal Unpaid Leave (Specify Reason): ____

☐ Other (Specify Reason): ____

Leave Request: (e.g. 01/31/2003) From / / to / /	Last Day Worked: / /	Intermittent Leave ☐ No ☐ Yes

Reason for Employee Leave: (If leave is for a family member, explain the care you will provide)

____
____
____

Please read the following statements. Your signature below will serve as confirmation that you have read and understand these guidelines.

- I have received and read the Family and Medical Leave Act Notice included in this packet of information.
- I have read my employer's policies specific to leaves of absence.
- I understand I have 15 days to submit FMLA forms for review.
- I understand my failure to complete any of the required forms within the specified timeframes above may result in the denial of my leave and discontinuation of pay.
- I understand a Return to Work Certification form, if applicable, that includes job restrictions and requests for accommodations must be completed and submitted to my Human Resources Representative three days prior to my return to active work.
- I understand failure to return to work or to keep my employer and FTD Leave Management informed of my return to work may constitute job abandonment and lead to termination of my employment with FTD.
- I hereby authorize my employer's designee to contact me or my family member's treating health care provider to clarify or authenticate the medical certification if applicable.

EMPLOYEE'S SIGNATURE (Must Sign to Proceed with Leave Request)	DATE (e.g. MM/DD/YYYY)