

APPLICATION - FAMILY OR MEDICAL LEAVE (FMLA)

Each employee who seeks benefits for Family and Medical Leave must complete all information requested. It is your responsibility to ensure that your employer completes the information as directed concerning your leave. It is your responsibility to ensure that the completed application is returned to the Harrison Electrical Workers Trust Fund. If you or your employer need additional space to complete a question, please attach an additional sheet of paper.

Full Name - Please Print

Social Security Number

Address

City

State/Zip

Date of Birth

() _____
Telephone

- Are you participating in the Harrison Electrical Workers Trust Fund as a Category 1 or Category 2 employee:
(Check One) Category 1 _____ Category 2 _____
- Provide the name, address and telephone number of your current employer:

Application - Family & Medical Leave

- Have you already applied to your employer for family and medical leave? (Check One) Yes _____ No _____
If your answer to question 3 is **yes**, answer the following questions:
 - Was your request granted? Yes _____ No _____
 - Name/job title of the individual who granted or denied your request: _____
 - If your request for leave was granted, when will it start? _____
 - Do you intend to return to work for your employer following the FMLA? (Check One) Yes _____ No _____
- If your answer to question 3 is **no**, answer the following question:
 - When do you intend to apply to your employer for family and medical leave? _____
- Please state the basis for your application for family and medical leave:
(Check appropriate box)
 - Birth of a child or placement of a child for adoption or foster care.
 - To care for a spouse, child or parent with a serious health condition.
 - Your own serious health condition. *
 - Your own Pregnancy Estimated Due Date: _____

I certify that the answers to the questions on this application form are true and correct.

Sign Your Name

Date

*A serious health condition is defined as an illness, injury or impairment, including: (i) inpatient treatment; (ii) absence from work or school for three or more days with continuing treatment by a health care provider; (iii) continued treatment by a health care provider or a condition which is incurable or serious enough to result in three or more days of incapacity; or (iv) parental care.

Application - Family & Medical Leave

EMPLOYER QUESTIONS

1. Has _____ applied to you for family and medical leave?
(insert applicant's name)
(check one) Yes _____ No _____

2. If your answer to question 1 is **yes**, state the period-of-time the employee will be off work for family and medical leave.

From: _____ To: _____

3. Indicate the total length of time _____ has worked for your company _____
(insert applicant's name)

(If this employee has worked for your company on several occasions, total all time worked.)

4. Has _____ worked for your company at least 750 hours in the 12-month
(insert applicant's name)
period of time immediately preceding the family and medical leave? Yes _____ No _____

5. Please state the reasons(s) or condition(s) that resulted in your company granting family and medical leave to _____
(insert applicant's name)

I certify that the answers to the questions on this application form are true and correct.

Sign your name

Date

Job Title