Diocese of Houma-Thibodaux

FMLA Request Form

The employee must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days is not possible, the employee must provide notice as soon as practicable and generally must comply with the location's normal call-in process. If you are requesting a leave of absence for reasons other than your own illness or that of an immediate family member, contact your immediate supervisor.

Name: _____Position: _____

Parish/School/Agency: _____ Employee Address:_____

☐ I hereby request a continuous leave of absence from ____-____-____to____-____- ____for _____

☐ I hereby request an intermittent leave of absence from _____-_____-_____ to____-____- _____for _____

Check one that applies:

☐ FLMA/ Employee ☐ FMLA/ Family Member ☐ Military Caregiver ☐ Qualifying Exigency

☐ Birth, Adoption or Forster Care of a Child ☐ Doctor's Verification, where applicable, is attached

Job Description Attached? Yes☐ No☐

If No, Statement of essential job functions: _____

_____

Employee's Regular Work Schedule: _____

EMPLOYEES RIGHTS AND RESPONSIBILITIES:

I understand that if I am granted a leave of absence as requested above, I am expected to return to work on or before _____. Should circumstances make it impossible for me to return by that date, I understand that I must apply for an extension before the expiration of my original leave. I understand that such extension will be subject to management approval and may be denied if the reason for the extension is not covered under the Diocese of Houma-Thibodaux's FMLA policy. I understand the following:

1. Continuous Family and Medical Leave of Absence are granted for a maximum of 12 weeks. Intermittent Family and Medical Leaves of Absence are granted for up to the equivalent of 12 full weeks' absence.
2. I am still considered and employee of the Diocese of Houma-Thibodaux while I am on leave.
3. All employee benefits in force at commencement of my leave will remain in force during my leave. The regular deductions for such benefits will continue to be take from my pay while I am on leave. However, at such time as my eligible paid time off benefits have been exhausted, I will be required to remit payment for the amount of the premiums by check monthly until I return form my leave.
4. My time spent on an approved leave of absence will be credited toward the accrual of my vacation benefits, provided I return on time and on a full-time or benefit-eligible basis. If I fail to return, or if I return only on a non-benefit eligible part-time basis, I will be entitled to only the unused vacation benefits, if any, I had accrued prior to going on leave.
5. I understand that I will be paid for any holidays observed while I am on leave.
6. I understand that if I return to work within the prescribed timeframe, I will be reinstated in my original position or an equivalent position with equivalent pay, benefits and other terms of employment.
7. By requesting this leave of absence, I am stating my desire and intention to return to work within the prescribed timeframe. I understand that my intention to return to work is a primary factor in determining whether or not my leave of absence will be approved.
8. I understand that if I am on a Medical leave of absence, my available sick time will be used for any medically necessary absences as certified by my physician. Should I exhaust all of my eligible sick days, I am required to use my unused vacation days. Under FMLA, my employer requires the use of my applicable paid time off benefits while I am on a leave of absence.
9. I understand that if I am enrolled in benefits for which my dependents are also eligible for coverage and that if I am on a leave of absence for the birth or adoption of a child, I must enroll new dependents within 30 days of the birth or legal adoption/guardianship of the child if I wish to add them to my current coverage.

10. I understand that upon my return to work following a Medical leave of absence I must provide my employer certification from my physician authorizing my return to work.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

RETURN THIS FORM TO THE OFFICE OF HUMAN RESOURCES @ treynolds@htdiocese.org