State of Connecticut Human Resources

Employee Request

For Medical Leave, Family Leave or Military Family Leave

For information about specific leave entitlements, contact your Human Resources Office

(To be completed by Employee)

Form **#: FMLA-HR1**
Revision Date: **12/2017**

Employee Name _____ **Employee No.** _____
Official Job Title _____ **Agency** _____
Supervisor _____ **Supervisor Phone No.** _____
Work Location _____ **Shift** _____**Hours** _____
Home Address _____
City_____ **State** _____ **Zip Code** _____
Employee's Personal Phone No. _____
Employee's Personal Email _____

REASON FOR LEAVE: (*Check reason)*

For information about specific leave entitlements, contact your Human Resources Office

Personal Medical Leave (for your own serious health condition): ☐ **My own illness or injury** ☐ **Disability period related to my pregnancy and childbirth** ☐ **Organ donation** ☐ **Bone marrow donation**	**Caregiver Leave (care for family member in connection with her disability period related to pregnancy and childbirth, or his or her organ or bone marrow donation, or other serious health condition):** ☐ **Spouse** ☐ **Parent** ☐ **Parent-in-law** *(State FMLA only)* ☐ **Child (under age 18 or age 18+ and incapable of self-care due to a disability)**
BondingLeave: ☐ **Birth of child** ☐ **Adoption of child** ☐ **Placement of foster child** *(Federal and state FMLA only)*	**Military Family Leave:** ☐ **Qualifying Exigency arising out of the covered active duty of my spouse, parent, or son or daughter** ☐ **Military Caregiver leave for my spouse, parent, son, daughter or next of kin who is a covered servicemember** ☐ **Military Caregiver leave for my spouse, parent, son, daughter or next of kin who is a covered veteran** *(Federal FMLA only)*

Does your spouse work for the State? ☐ *(yes)* or ☐ *(no)*

If YES: Spouse's Name: _____Spouse's Agency: _____

Will he/she be taking leave for the same purpose? ☐ *(yes)* ☐ *(no)*

TYPE OF LEAVE REQUESTED: (Check all that apply)

☐ **Block Leave**: A continuous absence for a single qualifying reason (e.g., one month).

☐ **Reduced Schedule Leave**: A leave schedule that changes the employee's normal work schedule for a period of time by reducing the employee's usual number of working hours per workweek or hours per day.

☐ **Intermittent Leave**: Leave taken in separate blocks of time due to a single qualifying reason.

NOTE:
Intermittent leave and reduced schedule leave are not available in all situations. Availability of these types of leave depends upon the reason for leave and your eligibility for specific leave entitlements. Contact your Human Resources Department for more information.

Duration of Leave: (*from*) _____ (*to*) _____
(month/day/year) (month/day/year)

Please describe your leave request:

_____

_____

_____

_____

_____

REQUESTED USE OF ACCRUALS:

- The choice to use your accruals during your absence must be made before you begin your leave.
  - If you want to change your accrual designation, you must contact your Human Resources Office.
  - Accrual changes will be applied prospectively.
- If the reason is for your own personal medical leave:
  - Sick leave accruals must be used.
  - Sick leave accruals must be exhausted before other earned accruals can be used.
- If you do not elect to use your accruals, the leave will be unpaid.
- If you choose not to use all of your accruals or if your accruals are exhausted before the leave ends, the remainder of the leave will be unpaid.
- If you elect to use your accruals, that paid time must be spent down completely before you go into unpaid status.
- You cannot intermingle unpaid time with paid time.
- Depending upon the reason for leave and your eligibility for specific leave entitlements, you may be allowed to use sick leave accruals for leave associated with bonding with a newborn child or newly placed adoptive child and for caregiver leave. Your Human Resources Office will notify you if you meet the criteria for use of sick leave accruals for these reasons.

Fill In Chart: You must designate the number of days, or hours, or you may indicate "ALL available."

USE OF ACCRUALS	**Sick Leave Accruals**	**Vacation Accruals**	**Personal Leave**	**Comp Time**	**Sick Family Days** *(based on bargaining unit contract)*	**Parental Days** *(based on bargaining unit contract)*
REASON	**Days/Hours**	**Days/Hours**	**Days/Hours**	**Days/Hours**	**Days/Hours**	**Days/Hours**
PERSONAL MEDICAL LEAVE						
My own illness or injury					Not Applicable	Not Applicable
Disability period related to my pregnancy & childbirth					Not Applicable	Not Applicable
Organ donation *(after exhaustion of paid leave entitlement of 15 days)*					Not Applicable	Not Applicable
Bone marrow donation *(after exhaustion of paid leave entitlement of 7 days)*					Not Applicable	Not Applicable
CAREGIVER LEAVE						
Spouse *(including providing care to your wife during the disability period associated pregnancy and childbirth)*						Not Applicable
Parent						Not Applicable
Parent-in-law					Not Applicable	Not Applicable
Child						Not Applicable
BONDING LEAVE						
Birth of child					Not Applicable	
Adoption of child					Not Applicable	
Placement of foster child					Not Applicable	Not Applicable

USE OF ACCRUALS	**Sick Leave Accruals**	**Vacation Accruals**	**Personal Leave**	**Comp Time**	**Sick Family Days** *(based on bargaining unit contract)*	**Parental Days** *(based on bargaining unit contract)*
REASON	**Days/Hours**	**Days/Hours**	**Days/Hours**	**Days/Hours**	**Days/Hours**	**Days/Hours**
MILITARY FAMILY LEAVE						
Military Caregiver - Covered Servicemember						Not Applicable
Military Caregiver - Covered Veteran						Not Applicable
Qualifying Exigency leave					Not Applicable	Not Applicable

_____ _____

(Employee Signature) **(Date)**

Return the completed form(s) to your agency Human Resources Office.