



Family Medical Leave Act Employee Request Form

Employee Name (print clearly): _____

Job Title: _____ Unit: _____

Requested Leave Start Date: _____ Estimated End Date: _____

The reason for this FMLA leave request is (select the most appropriate box):

- Birth of a son or daughter and to care for the newborn child.
- Placement with the employee of a son or daughter for adoption or foster care.
- To care for the employee's spouse, son, daughter or parent with a serious health condition.
- Employee's own serious health condition.
- A qualifying exigency arising out of the fact that the employee's spouse, son, daughter or parent is a military member on covered active duty (or has been notified of an impending call or order to covered active duty status).
- To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the covered service member.

Time off work is expected to be (select the most appropriate box):

- For a continuous block of time (several continuous days, weeks or months off work).
- For a reduced work schedule (change in work schedule needed—fewer hours per day or fewer hours per week).
- On an intermittent basis (periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups of a medical condition and/or for ongoing medical treatment/appointments).

Employees may elect to use earned leave (such as sick, family personal, and annual leave) during FMLA. If an employee is on an approved FMLA Leave for his or her own illness, all available sick leave may be used in addition to other available leave types. Otherwise, only 33% of the sick leave balance can be used in addition to other available leave types.

I request to use leave as indicated (select the most appropriate box):

- Earned leave (sick, annual, family personal)
- Leave without pay (only an option when an employee has no earned leave)
- Leave rate of _____ hours each pay period and leave without pay rate of _____ hours each pay period
- Working rate of _____ hours each pay period and leave rate of _____ hours each pay period

FAMILY AND MEDICAL LEAVE GUIDELINES

I understand that to be eligible for leave under the Family and Medical Leave Act, I must have been employed with the RBC for a cumulative total of 12 months AND have physically worked a minimum of 1,250 hours during the 12 months immediately preceding the beginning of the requested leave. If I do not meet eligibility, I understand that my request under FMLA will be denied. If my request for FMLA leave is approved, I understand that this period of leave will count toward the number of workweeks that I am entitled to under the Act. I understand that the 12 month period is a rolling 12 month period measured backward from the first date I use any FMLA leave. I also understand that under the rolling 12 month period, each time I take FMLA leave, the remaining entitlement is the balance of my unused workweeks. I understand that FMLA requests must be renewed or extended if the request and approved FMLA period has elapsed.

CERTIFICATION

I understand that the Family and Medical Leave Certification or the Injured Service Member Health Care Provider Certification form is required at the time of my request for leave due to the serious health conditions of me or my child, spouse, or parent. In the case of placement of a child through adoption or foster care, I understand that appropriate documentation from the agency or jurisdiction placing the child is required. In order to take service-member family leave, I understand documentation from the appropriate branch of the Armed Forces is required referencing need for support of the contingency operation.

Employee Signature: _____ Date: _____

Additional information about employee FMLA rights and responsibilities will be provided to you in writing within five business days after receipt of this notice (unless already provided). Determination of eligibility for leave under the FMLA, and/or additional documentation or clarification of documentation, may be required prior to making a final FMLA determination to approve or deny an FMLA leave request. Please contact Human Resources with any questions.

**** Return to Human Resources Department ****

For HR use ONLY: Date received: _____ FMLA Eligibility Notice sent: _____ⁱ

ⁱ *This form should be treated as a medical record and must be maintained separately from employee personnel files, in locked cabinets with only designated personnel having access. RBC Human Resources shall retain this original and provide a photocopy of the form to the employee along with the RBC FMLA Designation Form within a reasonable period of time.*