City of Bloomfield
Request for Family or Medical Leave

1. I, _____, request a Family or Medical Leave of absence for the purpose of:

   a) Adoption or the placement of a child with me for foster care (___).

   b) The birth of my son/daughter, and in order to care for my newborn son/daughter (___).

   c) In order to care for the following family member who has a serious health condition: (___) spouse (___) son (___) daughter (___) father (___) mother.

   d) My own serious health condition (___).

2. I request to begin FMLA leave on _____, and to return on _____. I understand this is my obligation to confirm my return to work a minimum of one week in advance of my return.

3. I request intermittent or reduced leave as described below:

   _____

   _____

4. During this FMLA leave of absence, I (___) do (___) do not elect to continue my health plan coverage. (If continuation is not elected, the COBRA coverage will be offered for continuation of health coverage, if appropriate.)

5. I understand that I will return to my current position (job classification) or an equivalent classification to the extent required by the Family and Medical Leave Act, unless during my absence, there is a reduction in force or other reorganization, in which case I will be considered as if I had been actively employed.

6. As a condition of reinstatement of employment after a leave due to a **personal health condition**, I am required to provide certification from a health care provider that I am **able** to resume work.

7. I understand that a certification of a health care provider certifying the "serious health condition" is required.

_____ _____

Employee Signature Date