

Stillwater County Family Medical Leave Request

Submit this request form to the Human Resources specialist at least 30 days prior to the date when the leave is to begin, unless the leave is unforeseeable. If unforeseeable, the employee must give notice as early as is practical.

Employee Name: _____

Requested beginning date of Family Medical Leave (FML): _____

Anticipated ending date of FML: _____

Purpose of the leave: _____

The County may require certification from a health care provider containing specific information required under the law if this is for **medical leave**. Attach U.S. Department of Labor **Form WH-380** to this request if this is for medical leave. This form is available in the Finance and Human Resources office.

If applicable, the employee may elect to use all or part of accumulated sick leave.
Do you wish to use sick leave? Yes _____ No _____

If yes, how many days do you want applied to your FML? Days _____

If eligible, the employee may elect to use accumulated vacation leave.
Do you wish to use vacation leave? Yes _____ No _____

If yes, how many days do you want applied to your FML? Days _____

County Employees must use accrued sick leave concurrently with FML in accordance with County Policy.

Check the insurance plan which you are currently enrolled prior to your leave.

Employee	_____
Employee/Spouse	_____
Employee/Child(ren)	_____
Family	_____

The County will continue to pay the employer share of your medical premium, but you must make arrangements to pay the employee's share once regular paychecks are no longer being issued.

Have you used FML previously while with this employer?

Yes _____

No _____

If yes, what were the dates of that leave? Start date _____ End date _____

Employee _____ Date _____
Signature

To be completed by Human Resource Specialist

Date received: _____ Was form WH-380 attached? Yes ___ No ___

If Form Wh-380 was not attached, is form required to respond? Yes ___ No ___

If yes, date Form Wh-380 was mailed to employee _____