CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE REQUEST/NOTICE

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____ (_____) _____-_____
Home Address City State Zip Code Home Phone No.

(_____) _____-_____
Work Phone No.

☐ Form completed by employee.
☐ Form completed by supervisor based on information provided by employee. Describe circumstances and date information was provided_____.

A **"YES"** answer to any of the items in the chart below requires that the employer provide the employee with the following: (Employee's initials on line indicate receipt; supervisor's initials indicate distribution to the employee.)

☐ (1) A copy of the U.S. Department of Labor FMLA Fact Sheet #28: The Family and Medical Leave Act of 1993
☐ (2) A completed Notice to Employee of Responsibilities and Requirements of FMLA Leave Form WH-381 Substitute, Dec 1994
☐ (3) Leave Authorization Request, Revised P.D. Form 206
(4) The following form(s), where applicable, are to be completed and returned to the supervisor:
☐ (a) Statement of Family Relationship Form, if the leave request pertains to the employee's spouse, child or parent.
☐ (b) Certification of Health Care Provider, U.S. Department of Labor Form WH-380, if the leave request is for a serious health condition of the employee or an employee's covered family member.

Leave is due to the serious health condition of: **(Check One)** ☐ **Employee** ☐ **Child** ☐ **Spouse** ☐ **Parent**	***YES***	***NO***
1.) Does the condition arise from or require an overnight stay in a hospital, hospice, or residential medical care facility?	☐	☐
2.) Does the condition make the person unable to work, attend school or perform other regular daily activities for more than 3 consecutive calendar days, and is the person receiving continuing treatment for the condition by or under the supervision of a health care provider during the leave period?	☐	☐
3.) Is the absence because of an incapacity due to pregnancy or for prenatal care, and is the person receiving continuing treatment for the pregnancy or prenatal care from a health care provider?	☐	☐
4.) Is this a chronic condition (for example, diabetes, asthma, epilepsy, etc.) for which the person is receiving continuing treatment from a health care provider?	☐	☐
5.) Is this a permanent or long-term incapacity for which treatment may not be effective (for example, Alzheimer's, severe stroke or terminal stages of a disease) and the person is under the continuing supervision of a health care provider?	☐	☐
6.) Is the absence needed to receive multiple treatments from, under the supervision of, or on referral by a health care provider, either for restorative surgery after an accident or injury or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment (for example, chemotherapy, radiation, dialysis)?	☐	☐
7.) Leave is due to birth, placement or parenting. Check One: ☐ Birth and/or care of the child within 12 months of birth ☐ Adoption or foster care placement and/or care within 12 months of placement	☐	☐

_____ _____/_____/_____ PWE
Employee's Signature Date Department

_____ _____/_____/_____ PWE
Supervisor or Designee Signature Date Department

Form B