LOUISIANA DEPARTMENT OF HEALTH

HR-31
Revised October 2024

FMLA ALERT FORM

This form is to be completed by the employee's supervisor upon receipt of a leave request that may be FMLA-related or upon the fourth day of an absence of more than 3 consecutive days. Please submit completed form to Human Resources.

Employee Name: _____ **Personnel #:** _____

Supervisor Name: _____ **Time Administrator Name/Phone #:** _____

Supervisor Phone#: _____ **Office:** _____

FMLA qualifying event:

☐ Employee requesting leave due to his/her own serious health condition

☐ Employee absent for more than three consecutive days due to illness or injury

☐ Employee requesting leave to care for a family member with a serious health condition:

Name of family member _____

Relationship to employee _____

☐ Employee requesting leave related to a family member's/next of kin's military service

Employee Personal Email Address (optional): _____

Start date of anticipated leave:_____

Expected return to work date: _____

Supervisor Signature: _____ **Date Signed:** _____

HR Use Only: FMLA Quota Entered _____(Date) By_____(Signature of HR Professional)