LOUISIANA DEPARTMENT OF HEALTH

HR-28
Revised October 2024

FAMILY AND MEDICAL LEAVE ACT EMPLOYEE REQUEST FORM

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

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

Employee Mailing Address: Street _____

City _____ State _____ Zip Code _____

Employee Contact Telephone #: _____

Employee Personal Email Address (optional): _____

Supervisor Name: _____

FMLA request is for:

☐ Self – serious health condition ☐ Self – pregnancy

☐ To care for a family member with a serious health condition:

Name of family member _____

Relationship to employee _____

☐ Leave related to a family member's/next of kin's military service

If married, is your spouse a state employee? ☐ **Yes** ☐ **No**

Start date of anticipated leave:_____

Expected return to work date: _____

Employee Signature _____ Date Signed _____

I am aware of this FMLA request:

Supervisor Signature _____ Date Signed _____

PLEASE SUBMIT COMPLETED FMLA EMPLOYEE REQUEST FORM TO HUMAN RESOURCES

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