WHITMAN COUNTY
400 N. MAIN ST.
COLFAX, WASHINGTON 99111

Family & Medical Leave Request

This form must be completed and returned to the Human Resources Director when you request FMLA. Unless for pregnancy or the adoption of a child, a Health Care Provider's Certification must be attached.

Name:

Date: Department: _____

Title: _____

I'm requesting a leave of absence from _____to _____for the reasons listed below:

☐ My pregnancy/adoption of a child

☐ My serious health condition

☐ The serious health condition of my spouse, child, parent, parent-in-law or grandparent

I'm requesting that leave be:

☐ Continuous

☐ Intermittent

If intermittent, please explain your plan: _____

- I understand that, except for pregnancy/adoption, I must attach a doctor's certification to this form. That certification must specify that my family member or I are under the doctor's care, the nature of the condition, and how long I will be away from work.

- I understand that my position may be temporarily filled while I am on leave.
- I understand that I may be required to provide doctor certification throughout my leave and upon my return to work.
- I understand that I am responsible for the continuing medical insurance premiums that I paid for prior to my leave.
- I understand that failure to return to work, under certain circumstances, may obligate me to reimburse the County for medical insurance premiums it made while I was on leave.
- I understand that I am entitled to 12 weeks of leave as long as I continue to qualify for FMLA. At the end of that 12 weeks, if I do not return to work, I understand that Whitman County does not have an obligation to continue my employment under the FMLA. I may then communicate with the County regarding other forms of leave.

_____ _____

Signature Date

_____

Representative Signature

_____

If signed by a representative, state the nature of your relationship with the employee