CATHOLIC CHARITIES
DIOCESE OF PALM BEACH

EMPLOYEE'S REQUEST FOR FMLA LEAVE

An employee intending to take Family or Medical Leave must notify his/her supervisor at least thirty (30) days before the leave is to begin (when the leave is foreseeable). For additional information regarding Family and Medical Leave, please consult the Personnel Policy Manual.

Employee Name____________________________________Date__________________
Employee Title__________________________Program Location_________________
Employee Social Security Number_______________________Date of Hire_________
Status: Full Time______ Part Time______ Hours/week___________
Does your spouse work for the Catholic Charities? Yes____ No____
Employee Home Address____

Employee Home Phone Number___________________________
Employee Work Phone Number___________________________
Current Health Insurance Coverage: EE_______ EE+1________ EE+2_______
Reason for requesting leave:
_____ To care for my child after a birth, or placement by adoption or foster care.
_____ To care for my spouse, child or parent who has a serious health condition.
_____ Because my own serious health condition makes me unable to perform the essential functions of my job.

Leave is to be taken all at once (rather than intermittently):
Date you plan to start your leave:______________________
Date you plan to return to work:_______________________

If leave is to be taken intermittently, please outline the schedule of time off needed:
____
____

Employee Signature___________________________________Date_______________
Supervisor Signature__________________________________Date_______________
Supervisor Print Name_________________________________
Division Director Signature_____________________________Date_______________
Human Resources Director Signature_____________________Date______________

Following review by the Division Director, please forward the original of this form to the Human Resources Director.

CONTINUATION OF BENEFITS WHILE ON A LEAVE OF ABSENCE or FMLA

Name of Employee________________________________
Program Location_________________________________
Dates of Leave: From_________________ Through _______________

Arrangements regarding continuation of your benefits must be made *prior* to the beginning of your leave of absence.

Type of Insurance	Type of Coverage	Cost
Health	Individual ____	___________per_________
	Employee + 1____	___________per_________
	Employee + 2____	___________per_________
Dental	Individual ____	___________per_________
	Employee + 1 ____	___________per_________
	Employee + 2 ____	___________per_________
Other____________	________________	_______________________

Please check below all that apply:

____ I wish to maintain the benefits checked above while I am on a LOA.

You are expected to pay Catholic Charities at the beginning of each month by sending in a check made out to Catholic Charities to the attention of the Human Resources Director. If extenuating circumstances prevent you from doing this, please contact the HR Director.

____ I do not wish to continue my medical benefits listed above.

____

Employee Signature **Date**

____

Program Administrator Signature **Date**

____

Human Resources Director Signature **Date**

2/18/03

FMLA Certification Form

To: Health Care Provider
Re: ________________________________ (Name of Patient)

Please be advised that our employee ____ has requested a Family & Medical Leave of Absence. His/her reason given was____.
Would you kindly provide the following information:

1. **The date on which the above reason commenced______________________.**
2. **The probable duration of the condition._____________________________.**
   ____.
3. **The appropriate medical facts within your knowledge as the health care provider regarding the condition____________________________________.**
   ____.
4. **Is the employee unable to perform the functions of his/her position as a result of such as condition?____.**
5. **Please specify all functions of the employee's position that he/she is unable to perform as a result of such a condition_________________________________**
   ____.
6. **Is the employee needed to care for the son, daughter, spouse, or parent?**
   ____.
7. **The probable length of time the employee will be needed to care for the son, daughter, spouse, or parent?______________________________.**
8. **Please provide an estimate of the amount of time each day, week, or month that the employee is needed to care for the son, daughter, spouse, or parent____.**
9. **Is intermittent leave requested? If "No", please complete the signature block provided in this document. Thank you.**
10. **If the answer to #7 is "Yes", is such leave for planned medical treatment. If yes, please provide the dates on which such treatment is expected to be given and the duration of such treatment:**

    ____
    ____
    ____
    ____.
11. **If the answer to #7 is "Yes", please provide a statement explaining the medical necessity for the intermittent leave and the expected duration of the medically necessary intermittent leave._________________________________**
    ____
    ____.

Your Name/Title Printed____

Your Signature____

Your Direct Dial Telephone Number ___(   )______________________________

Your Office Address____
____

Your Email Address____

Please submit this completed form to:
Human Resources Director
c/o Catholic Charities
Diocese of Palm Beach
P.O. Box 109650
Palm Beach Gardens, Florida
33410-9650

561-775-9564

Thank you for your time and attention to this matter.

2/18/03