CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE REQUEST/NOTICE

Employee Name____ S.S. #________________

Home Address______________________________ Zip________ Home Phone # ________________

☐ 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 Highlights, FMLA Fact Sheet No. ESA 93-24*

___ (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, which 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, Form WH-380 Substitute, Dec. 1994*, 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, <u>and</u> 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, <u>and</u> is the person receiving continuing treatment for the pregnancy or prenatal care by a health care provider?		
4. Is this a chronic condition (for example, diabetes, asthma, epilepsy, etc.) for which the person is receiving continuing treatment by 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 by, 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 of 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	Yes	No

________________________ ________________________

Employee Signature Supervisor Signature

________________________ ________________________

Department Date