CS-1810
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State of Michigan

Leave of Absence Application
For FMLA, Medical (Including Extended Use of Leave Credits), and Parental Leaves Only

Contact your HR Office for the appropriate form for other leaves of absence

Employee completes Section I (Page 1) ONLY:

Sections II and III are completed by the HR Office

Employee Information	
Employee's Name	Employee's ID Number
Home Address	Home E-mail (optional)
Cell/Home Work	Leave Dates: From: To: ☐ Intermittent Leave or Reduced Work Schedule
Supervisor Name Supervisor Phone	Department Name

Reason for leave (check one)

- ☐ A serious health condition that makes you unable to perform the essential functions of your job.
- ☐ A serious health condition affecting your ☐spouse, ☐child, ☐parent, for which you are needed to provide care.
- ☐ Maternity leave for the birth of a child. (Estimated due date)
- ☐ Parental leave after a child's birth or for a child's placement with you for adoption or foster care.
- ☐ A qualifying exigency arising from your ☐spouse, ☐child, or ☐parent being on covered active duty or having been notified of an impending call or order to covered active duty in the Armed Forces.
- ☐ To care for a covered service member for whom you are the ☐spouse, ☐child, ☐parent, or ☐next of kin.

Leave Credits Options – Select below and also notify your supervisor of your selections.

- Consult your collective bargaining agreement or civil service regulations.
- Sick leave must be exhausted before an unpaid medical leave of absence for your own personal illness.
- If sick leave will be exhausted before you return to work, please specify your preferred use of other leave credits.
- **If no preference is stated, leave credits will be frozen when available. Freezing leave credits may affect your eligibility to receive annual leave donations.**

LEAVE CREDITS	USE ALL	FREEZE ALL	ENTER AMOUNT TO FREEZE
Annual Leave	☐	☐	
Banked Leave	☐	☐	
Deferred Hours	☐	☐	
Comp Time	☐	☐	
Sick Leave (May only be frozen for Family Care or Military Caregiver Leave)	☐	☐	

Acknowledgement

I understand that if approved, my leave may count towards my leave entitlements under the federal Family and Medical Leave Act, Civil Service rules, departmental policy and collective bargaining agreement. I certify that my leave credits should be used as stated above, where authorized, and I understand that my leave credit selections are binding.

Employee Signature	**Date**

Section II – Family Medical leave Act (FMLA) Notice of Eligibility, Rights, and Designation/Eligibility Determination and Required Certifications – Completed by Human Resources

1. Employee's Name	2. Employee's ID Number

3. Eligibility Determination. On _____ *(date)* you informed us that you needed FMLA leave.

☐ You are eligible for leave under the FMLA. You appear to be eligible for _____ *(remaining time)* for the rest of your 12-month FMLA entitlement period ending _____ *(date)* for ☐ servicemember family leave ☐ other FMLA leave. *(Complete rest of Section II before signing and providing form to employee.)*

☐ You are not eligible for leave under the FMLA. *(Explain why, sign form, and provide to the employee.)*

If eligible, you have a right under the FMLA for up to 12 weeks of leave in a 12-month period for the first four qualifying reasons listed in Section I. You also may be eligible for up to 26 weeks of leave in a 12-month period for qualifying care for a covered servicemember, although any other FMLA leave taken during that period will count toward your 26-week entitlement. Your health benefits can be maintained during any period of unpaid FMLA leave as if you continued to work. You must be reinstated to the same or an equivalent job with the same pay, benefits, and conditions of employment on your timely return from leave. You may have other leave options under civil service rules or a collective bargaining agreement. If circumstances change and you can return early, you must notify us at least two work days before you intend to report to work. Clarification and notice of your rights and responsibilities under the FMLA follows:

4. Additional Information. You meet the eligibility requirements, but to determine whether your absence qualifies as FMLA leave, you must return the following information by _____ *(date at least 15 calendar days after notice is provided to employee)*. If sufficient information is not timely provided, your leave may be denied.

☐ Sufficient certification to support your request for FMLA leave. The enclosed certification form must be returned.

☐ Sufficient documentation to establish the required relationship between you and your relative.

☐ No additional information is requested.

☐ Other information. *(Explain information needed.)*

5. Paid Leave Substitution. We ☐ will or ☐ will not require that you substitute accrued paid leave for unpaid FMLA leave. You have the right to elect to substitute accrued paid leave for unpaid FMLA leave as provided in your collective bargaining agreement or the civil service rules and regulations. If you do not meet the conditions for taking paid leave, you remain entitled to take unpaid FMLA leave. Any paid leave used counts against your FMLA leave entitlement. The following conditions will apply: *(Explain any conditions.)*

6. Insurances. To retain your health, dental, and vision insurance coverage during an unpaid FMLA leave, you must pay any required employee share of the biweekly insurance premiums. You may be required to repay the share of premiums paid by the department to retain your coverage if you do not return to employment after a FMLA-designated unpaid leave for reasons other than continuation, recurrence, or onset of a serious health condition or a covered servicemember's injury or illness or for other circumstances beyond your control.

☐ You have a 30-day grace period to make premium payments once you go off the payroll. You must make arrangements to pay your biweekly share of insurance premiums with your HR office. If not timely paid, your coverage will be canceled 15 days after we send written notice that your coverage will lapse.

☐ We will continue coverage and recover your share of insurance premiums from you upon your return to work.

7. Key Employee. You ☐ are or ☐ are not a "key employee," whose restoration to employment may be denied after FMLA leave, as authorized under the FMLA, because we have determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm.

8. Periodic Reports. While on leave, you ☐ will or ☐ will not be required to furnish us with periodic reports every _____ *(indicate interval, as appropriate for particular situation)* of your status and intent to return to work.

9. This eligibility form was provided to the employee on _____ *(date)* by _____ *(name)* by:

☐ Personal delivery ☐ First-class mail ☐ Return receipt requested ☐ Other _____

After receiving any required information indicated in Section II, #4, your HR Office will respond within 5 business days indicating whether the leave is designated as FMLA leave and will count toward your FMLA leave entitlement. This designation will be accomplished by reissuing this form to you with Section III below filled in.

Section III – Designation of FMLA Leave – Completed by employer after receiving certification

We have received your most recent information on _____(date) and decided as follows:

1. ☐ Your requested leave is approved from *(date)* _____ to *(date)* _____. All leave taken will count against your FMLA entitlement. Please see Section II, #5 above for information on paid leave substitution and your FMLA leave.

☐ The certification you provided is insufficient to determine your eligibility. By _____ *(date at least 7 calendar days after notice provided to employee)*, you must provide the following or your leave may be denied: *(Explain what information is needed to make the certification complete and sufficient below.)*

☐ We are requiring an additional medical certification at our expense and will provide further details later.

☐ Your requested leave does not meet the requirements for FMLA leave. *(Explain why below.)*

2. You ☐ will or ☐ will not be required to furnish recertification relating to a serious health condition. *(Explain below, including the interval between certifications. See §825.308 of the FMLA regulations for conditions.)*

3. ☐ If your anticipated leave schedule does not change, _____ will count against your FMLA entitlement.

☐ It is not possible to calculate how much leave will count against your FMLA entitlement now. You have the right to request this information once every 30 days from your HR office (if leave was taken during the 30 days).

4. You ☐ will or ☐ will not be required to present a fitness-for-duty certificate before being restored to employment. If a required certification is not received, your return to work may be delayed until it is provided. If a list of essential functions is attached to this form, your fitness-for-duty certification must address your ability to perform the functions.

5. This designation form was provided to the employee on _____ *(date)* by _____ *(name)* by:

☐ Personal delivery ☐ First-class mail ☐ Return receipt requested ☐ Other _____

If you have questions about your entitlements to FMLA leave, contact _____at _____.