ST. CROIX CHIPPEWA FAMILY AND MEDICAL LEAVE ACT POLICY REQUEST FORM

Date: _____

Please Note: Request for SCT Family or Medical Leave must be made, if practical, at least thirty (30) days prior to the date requested leave is to begin. Please return request to your supervisor. Please allow one (1) week for request to be processed.

Employee Name: _____ Title/Position: _____

Department: _____ Reports to: _____

Employee Payroll Number: _____ Hire Date: _____

Employee Type: Part Time ___ Full Time ___

I REQUEST A FAMILY OR MEDICAL LEAVE FOR ONE OR MORE OF THE FOLLOWING REASONS: (CHECK ONE)

_____ Because of the birth of my child and in order to care for him/her.
Expected date of birth: _____ Actual date of birth (if applicable): _____
Leave to start: _____ Expected return date: _____

_____ Because I am the___ spouse ___son or daughter ___ parent ___ next of kin of a covered service member with a serious injury or illness. (Submit medical documents.)

_____ Because of a qualifying exigency arising out of the fact that my ___ spouse ___son or daughter ___ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves. (Submit certification.)

_____Because of the placement of a child (with me) for adoption or foster care. (Submit legal records.)
Date of placement: _____
Leave to start: _____ Expected return date: _____

_____ In order to care for my spouse, child or parent, who has a serious health condition. (Submit medical documents.)
Leave to start: _____ Expected return date: _____

_____ For a serious health condition that makes me unable to perform my job. (Submit medical documents.)
Leave to start: _____ Expected return date: _____

Have you taken a family or medical leave in the past twelve (12) months? ___ Yes ___ No If yes, how long? _____

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- I am aware that in order to be considered eligible for SCT FMLA, I must have been employed with the St Croix Chippewa for at least twelve (12) months and worked a minimum of 1,250 hours preceding the start of my requested leave.
- If I normally pay a portion of any insurance, these payments must continue during the period of SCT FMLA leave. Payment arrangements should be discussed with the Benefits Department and put in writing.
- This leave may be unpaid, unless it is company policy to be paid, or payment may occur under a company disability or other insurance plan under which I may be covered.
- I may be required to use my time off accrued as part of my twelve (12) weeks of leave.
- If after the amount of SCT FMLA leave granted has been fulfilled, I do not return to work or contact my supervisor or manager on or before my expected date of return, the company may assume that I have abandoned my job.
- I am responsible for contacting my supervisor for my exact date of return to work.
- I have read and understand the current St Croix Chippewa Family and Medical Leave Act Policies in place.

Employee Signature: _____ Date: _____

SUPERVISOR INFORMATION / ACKNOWLEDGEMENT:

Name (Printed): _____ Signature: _____

Job Title: _____ Date: _____

LEAVE PROCESSING:

Has employee been at the company for at least twelve (12) months? ___ Yes ___ No

Explain: _____

Has employee worked at least 1,250 hours during the previous twelve (12) months? ___ Yes ___ No

Explain: _____

Has employee submitted required documentation? ___ Yes ___ No

___ Leave approved ___ Leave denied - copy of all notice(s) attached.

Name (Printed): _____ Benefits Signature: _____

Job Title: _____ Date: _____

PAYROLL INSTRUCTIONS:

___ With Pay ___Without Pay

Additional Instructions:

(Proposed intermittent or reduced day schedule, if applicable. Maybe be subject to supervisor/employer's approval.)

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