



Douglas County, Nebraska

FAMILY AND MEDICAL LEAVE APPLICATION FORM

Email to: FMLA@douglascounty-ne.gov

FAMILY AND MEDICAL LEAVE REQUEST INFORMATION

Name: _____

Department: _____

Work Phone: _____ Primary Phone: _____

Home Address: _____

Last 4 digits of SSN: _____

I am requesting Family and Medical Leave for the reason indicated in the checked box:

- My own serious health condition
- Emergency Medical Leave Act (EMLA - COVID-19 Childcare per DOL Guidelines)
- Birth of my son or daughter (anticipated delivery date) _____
- Placement with me of a child for adoption/foster care (anticipated date) _____
- Care for my spouse, parent, or child with a serious health condition

Name: _____

Relationship: _____

If child, date of birth: _____

- Care for my spouse, child, parent, or relative to which I am the next of kin who has an illness or injury incurred during active military duty.

Name: _____

Relationship: _____

- Leave for my spouse, child, or parent being on or called to active military duty.

Name: _____

Relationship: _____

LEAVE TYPE REQUESTED

Please check all that apply:

- Consecutive beginning on _____ and continuing to _____
- Reduced schedule beginning on _____ and continuing to _____
- Intermittent beginning on _____ and continuing to _____

FMLA LEAVE INFORMATION

1. If FMLA is for a family member, what care will you provide and for how long will the care be provided?

2. Does your spouse work for the County? Yes No

If yes, please provide the following information:

Spouse's Name: _____

Spouse's Department: _____

EMPLOYEE AUTHORIZATION AND SIGNATURE

I agree to abide by the Civil Service Family and Medical Leave Act Policy and applicable federal law and regulations.

I understand that once my requested paid leave is exhausted any remaining leave will be without pay.

I understand my leave may be delayed until the Medical Certification Form (must be received within 15 days) is returned by my healthcare provider.

I understand that when my FMLA is for my own serious health condition, I may not return to work until I present to my Elected Official/Department Head a Release to Return to Work form completed by my healthcare provider.

I understand that if I do not return to work as indicated on the Return to Work form (or another date as specified by me and agreed to by my Elected Official/Department Head), my employment may be terminated as of the date my leave expires.

Employee's Signature

Date

HUMAN RESOURCES REVIEW

Based upon review of the Medical Certification, application is approved: Yes No

Signature

Date