

**Catholic Diocese of Dallas**  
**Employee Request for Leave**  
**Under the Family and Medical Leave Act (FMLA)**

The following form must be completed by you and returned to your Business Office in order to serve as your request for job protected time off under the Family and Medical Leave Act (FMLA).

In general, to be eligible for FMLA, an employee must have worked for at least 12 months, and have worked at least 1,250 hours in the 12 months preceding the leave request.

Your FMLA leave entitles you to unpaid, job-protected leave for up to twelve work weeks. In addition, all of your benefits will be maintained. Your portion of such benefits will remain your responsibility. If applicable, you may choose to use any or all of your accrued paid time off before you go on FMLA leave.

If your request for FMLA leave is due to a serious illness of your own, then you are required to supply a doctor's note releasing you to work in order to continue your employment.

If you have any questions or concerns, please contact your Business Office.

**Catholic Diocese of Dallas**  
**Employee Request for Leave**  
**Under the Family and Medical Leave Act (FMLA)**

Date: \_\_\_\_\_

Location: \_\_\_\_\_

This serves as my request for leave under the Family and Medical Leave Act. I am requesting leave for the following reason:

- \_\_\_\_\_ The birth of a child, or placement of a child with me for adoption or foster care.
- \_\_\_\_\_ A serious health condition of my own.
- \_\_\_\_\_ A serious health condition of my spouse, child, parent that requires my care.
- \_\_\_\_\_ A qualifying situation that arose out of the fact that my spouse, son/daughter, or parent is on active duty or called to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- \_\_\_\_\_ I am the spouse, son /daughter, parent, or next of kin of a covered service member with a serious injury or illness.

I understand that additional information may be requested of me by my employer to support my reason for leave.

I would like for my FMLA leave to begin on \_\_\_\_\_.

I am requesting the following type of leave (please check one):

- \_\_\_\_\_ ***Continuous FMLA leave:*** An employee is absent for more than three consecutive business days and has been treated by a doctor.
- \_\_\_\_\_ ***Intermittent FMLA leave:*** An employee is taking time off in separate blocks due to a serious health condition that qualifies for FMLA. Intermittent leave can be in hourly, daily, or weekly increments.
- \_\_\_\_\_ ***Reduced schedule FMLA leave:*** An employee needs to reduce the amount of hours they work per day or per week, often to care for a family member or to reduce stress.

Sincerely,

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Employee Social Security #

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

*(Should you need or want to provide additional information, please attach to this request form.)*