Miami-Dade County
Family and Medical Leave Act (FMLA) Request Form

SECTION I– EMPLOYEE INFORMATION

Last Name: _____ First Name: _____ Employee ID: _____

Job Title: _____ Personal Email: _____ Personal Phone: _____

Supervisor: _____ Business Unit: _____ Department: _____

SECTION II– REASON FOR LEAVE (CHECK ALL THAT APPLY)

Leave due to a serious health condition or to care for a family member must be accompanied by a written medical certification from the applicable health care provider. Failure to provide the certification in a timely manner may result in delaying your approval. You may also be required to provide periodic recertification of the medical condition. A serious health condition is an illness, injury, impairment, physical or mental condition that involves either inpatient care or continuing treatment by a health care provider.

☐ The birth of a child or placement of a child with you for adoption or foster care

☐ Your own serious health condition (Includes qualifying on-the-job injuries)

☐ You are needed to care for your family member due to a serious health condition. Your family member is your:

☐ Spouse ☐ Parent ☐ Child under age 18 ☐ Child 18 years or older and incapable of self-care because of a mental or physical disability ☐ Domestic partner and/or their children

☐ Grandparent due to his/her serious health condition (Covered in section 27.01 of the County Leave Manual and Family Leave Ordinance-FLO)

☐ A qualifying exigency arising out of the fact that your family member is on covered active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves. Your family member is your:

☐ Spouse ☐ Parent ☐ Child of any age

☐ You are needed to care for your family member who is a covered service member with a serious injury or illness. You are the service member's:

☐ Spouse ☐ Parent ☐ Child ☐ Next of kin who is a covered service member with a serious injury or illness

Note: When Family and Medical Leave is needed to care for a family member or Military Caregiver (also known as covered service member), you must state the care you will provide and an estimate of the time period during which this care will be provided, including a schedule of intermittent leave or leave on a reduced work schedule, if requested.

SECTION III – ELIGIBILITY

In general, an active employee is eligible for leave under the Family and Medical Leave Act provided that:

(1) You have been employed by Miami-Dade County for at least 12 months (need not be consecutive months); and (2) You have worked for the County 1,250 hours or more in the 12-month period immediately preceding the commencement date of leave, and (3) You must not have taken 12 weeks of leave under the Family and Medical Leave Act (FMLA) within the same calendar year.

SECTION IV– LEAVE REQUEST DETAILS

Anticipated Start Date: _____ **Anticipated End Date:** _____ **FMLA Type:** _____

I understand that I am required to use any applicable accrued leave hours until leave concludes or accrued balance is depleted. Pursuant to Miami-Dade County Leave Manual, Section 23.03.02, leave without pay may be approved by the Department Director when appropriate leave is available only under certain extenuating circumstances. Please complete:

I wish to use my accrued _____ leave

DO NOT use my accrued _____ leave

I wish to be WITHOUT PAY from _____ to _____

Please explain: _____

Employee Signature: _____ Date: _____

Department Director's Approval: _____ Date: _____

Required only for leave without pay requests

rev. 04/2023