GEORGIA DEPARTMENT OF HUMAN RESOURCES

FAMILY AND MEDICAL LEAVE REQUEST FORM

Name of Employee_____ **SS#**_____

Work Location _____

I request to use family and medical leave from _____ to _____
for the following reasons:

Please check:

_____ A. Pregnancy/birth of my child.

_____ B. Care of my newborn child.

_____ C. The adoption or foster care of a child, or care of the child after placement with me.

_____ D. A **serious health condition** (as defined in DHR Human Resource/Personnel Policy #1005 - FAMILY AND MEDICAL LEAVE) which renders me unable to perform my essential job functions.

_____ E. Care of my (*circle one*) child, spouse or parent who has **a serious health condition.**

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Please complete:

I request to use available leave during the period of absence as follows:

_____ hours of annual leave _____ hours of personal leave _____ hours of sick leave

I request to charge _____ hours to leave without pay during the period of absence.

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I understand that use of family and medical leave for any combination of circumstances listed above will be limited to a total of twelve (12) work weeks in a calendar year. I also understand that return to my former position or equivalent position with the same pay and grade, benefits and comparable working conditions is contingent upon compliance with the terms of approved family and medical leave.

_____ _____
Signature of Employee Date

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Does your spouse work for State government? ☐ yes ☐ no If yes, which agency?_____

_____ _____ _____
Name of Spouse Name of Spouse's Supervisor Supv. Phone #

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The original of this form and appropriate supporting documents should be submitted to the appropriate supervisor or authorized official. Please retain copies of all information for your records.