YOUTH SERVICES
FAMILY AND MEDICAL LEAVE ACT
EMPLOYEE REQUEST FORM

Date of Request: _____

Employee Name: _____

Position Number: _____

Home Address: _____
Street

_____ _____ _____
City State Zip Code

Home / Cell Telephone Number: _____

Agency: _____

Unit: _____

FMLA request is for: ☐ Self

☐ To care for a family member
Name of family member: _____
Relationship: _____

If married, is your spouse a state employee? ☐ Yes ☐ No

Briefly explain reason for FMLA request: _____

_____

_____

_____

Start date of anticipated leave: _____

Expected date of return: _____Employee Signature: _____

Date: _____

c: OSHCM/DPS Employee FMLA File