ARKANSAS DEPARTMENT OF FINANCE AND ADMINISTRATION
REQUEST FOR FAMILY AND MEDICAL LEAVE

Agency/Institution Name			Date *(MM/DD/YY)*
Employee Name *(Last, First, Middle)*			BEGIN FMLA: *(MM/DD/YY)*
Personnel Number	Business Area	Personnel Area	END FMLA: *(MM/DD/YY)*
Organization Unit	Job Title		Phone

Check all that apply:

☐ Yes ☐ No I am requesting Family and Medical Leave (FMLA) for the days shown above.

☐ Yes ☐ No I understand that FMLA, as federally mandated, is unpaid leave. However, all accrued paid leave, including Catastrophic Leave, must be exhausted before unpaid FMLA leave can be granted.

☐ Yes ☐ No I understand that DFA may require a written second opinion from a health care provider at the expense of the state.

☐ Yes ☐ No I understand that during FMLA, the agency/institution will continue paying the Employer portion of my group Health Plan, if I am a participant. I understand that I am responsible for paying the Employee's portion for the Health Plan for each pay Period. If I do not pay, my Health Plan may be cancelled after 30 days.

☐ Yes ☐ No The Employee Benefits Division may contact my Health Care Provider for clarification/authenticity of my medical certification if required.

☐ Yes ☐ No I am requesting unpaid FMLA.

☐ Yes ☐ No I am requesting that my accrued leave (paid leave) be substituted for unpaid leave.

Employee's signature	Date *(MM/DD/YY)*

ACKNOWLEDGEMENT:

Supervisor's signature	Date *(MM/DD/YY)*
Manager's signature	Date *(MM/DD/YY)*
Administrator's signature	Date *(MM/DD/YY)*

R 01/07/09

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