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**NORTH CAROLINA DEPARTMENT OF COMMERCE**  
**FAMILY AND MEDICAL LEAVE ACT (FMLA) APPLICATION**

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Employees requesting leave of absence under the Family and Medical Leave Act policy must fully complete this request form at least 30 days prior to the date of the requested leave of absence for birth, adoption of a child, care of an immediate family member with a serious health condition, a serious health condition that makes the employee unable to perform one or more functions of the position or Military Caregiver Leave. *Periods of paid leave and periods of leave without pay count towards the 12 workweeks to which the employee is entitled.*

**Employee's Name:** \_\_\_\_\_

**Office Location:** \_\_\_\_\_

**Reason for FMLA Request:** \_\_\_\_\_

**Last Actual Day at Work:** \_\_\_\_\_

**Options for FMLA**

Sick Leave Exhausted From \_\_\_\_\_ through \_\_\_\_\_

Annual Leave Exhausted From \_\_\_\_\_ through \_\_\_\_\_

(Available sick leave may be used for: period of disability related to childbirth (6 - 8 wks.), adoption of a child, care of an immediate family member with a serious health condition or Military Caregiver Leave. Sick leave shall be exhausted for employee's illness. A maximum of 30 days sick leave may be used for adoption.)

**Estimated Date of Return to Work:** \_\_\_\_\_

\_\_\_\_ I elect to exhaust leave as stated above. I understand that the periods of paid leave and periods of leave without pay count towards the 12 workweek benefit period per year to which I am entitled. (This includes leave without pay while drawing short term disability benefits and leave taken under the voluntary shared leave policy.)

\_\_\_\_ I have no available sick or annual leave and elect to go on leave without pay.

\_\_\_\_ I am requesting an intermittent or reduced work schedule.

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(EMPLOYEE SIGNATURE)

**\*\*Please attach copies of timesheets covering the entire period of leave, and certification of Health Care Provider (Family and Medical Leave Act of 1993) form and forward all to the Human Resources Office.\*\***

Period of Leave Requested is designated as Family and Medical Leave.

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(SUPERVISOR'S SIGNATURE)

**\*\*Verbal or written notification to be provided by supervisor within two business days after receipt of request and written confirmation given no later than the following pay day.\*\***

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(COMMISSION/DIVISION HEAD)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(PERSONNEL DIRECTOR)