City of Framingham
Human Resources Department
150 Concord Street, Room B7
Framingham MA 01702
508-532-5490

EMPLOYEE NOTICE of FAMILY or MEDICAL LEAVE

1. Employee's Name: _____
2. Department / Division: _____
3. Employee's Current Address: _____
4. Employee's Phone Number: _____
5. Employee's Personal *(non-work)* Email Address: _____

6. Patient's Name *(if other than employee)*: _____
7. Relationship to Employee: _____

8. **Type of FMLA Leave Requested:**

   ☐ Consecutive Months (up to 26 weeks)
   Beginning Date: _____

   ☐ Intermittent Leave
   Expected days / weeks / months on leave: _____

   ☐ Reduced Leave Schedule *(specify change in schedule)*: _____

9. **Please state the expected number of days (of each type) requested:**

   ☐ Vacation: _____ ☐ Sick: _____ ☐ Personal: _____ ☐ Unpaid: _____

10. **Reason for Leave:**

    ☐ Birth of a Child
    Estimated Date of Delivery: _____

    ☐ Placement of a child by foster care or adoption
    Date of Placement: _____

    ☐ Family member's "serious health condition"

    ☐ Employee's own "serious health condition"

Employee's Signature: _____ Date: _____