HIDALGO COUNTY

DEPARTMENT OF BUDGET & MANAGEMENT
EMPLOYEE BENEFITS DIVISION

2818 S. BUS HWY 281, EDINBURG, TX 78539 PHONE#: (956) 292-7025 FAX#: (956) 318-2610

FAMILY MEDICAL LEAVE
EMPLOYEE REQUEST FOR LEAVE

Employee Name: _____ Department: _____

Employee ID: _____ Employee's Position: _____

Reason for Leave:

☐ 1. Birth of a son or daughter of the employee and leave to care for such son or daughter.

☐ 2. Placement of a son or daughter with employee for adoption or foster care.

☐ 3. To care for spouse, child, or parent with a serious health condition.

☐ 4. Because of employee's own serious health condition that makes him/her unable to perform job functions.

☐ 5. Qualifying Exigency Leave for families of members of the National Guard and Reserves when the covered military member is on active duty or called to active duty in support of a contingency operation.

☐ 6. Military Caregiver Leave to care for an ill or injured service member.

If 3, 5 or 6, please check one:
Spouse ☐ Child ☐ Parent ☐

If 3, 5 or 6, state name and address of relation.
_____

Date: _____
Leave to commence

_____

Date: _____
Anticipated Return to Work

_____

Are you requesting leave on a full-time or intermittent basis? ☐ Full Time ☐ Intermittent

If intermittent, please give schedule of when you anticipate you will be available for work:

_____

Employees seeking leave because of reason 3, 4, 5 or 6 above must provide medical certification within 15 days or as soon as practicable.

Employees seeking to return to work after a leave because of their own serious illness, reason 4, must also provide medical certification of ability to perform job duties before they are allowed to resume work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse Hidalgo County for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with Hidalgo County until I provide medical certification, as appropriate.

_____ _____

Emp. Signature **Date:**

_____ _____

Dept. Head/Designee Signature **Date:**