DEPARTMENT OF HUMAN RESOURCES

505 South McColl, Suite A • Edinburg, Texas 78539 • (956) 318-2660

FAMILY MEDICAL LEAVE
EMPLOYEE REQUEST FOR LEAVE

Employee Name: ______________________________ Department: _________________________________
Employee Address: ______________________________ 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.
7. Workers' Compensation claim

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

State name and address of relation:
____ Date of leave to commence: ______________________
____ Date anticipated return of 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 reasons 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.

____ ________________________
Employee Signature Date

____ ________________________
Department Head/Designee Signature Date