



**APPLICATION FOR LEAVE OF ABSENCE
(For Family and Medical, Military, and Personal Leave Requests)**

Eligible associates are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 or 26 weeks of job-protected leave for certain family and medical reasons. **Submit this request form to the Benefits Department at least 30 days before your leave is to begin (if the leave is foreseeable), or as soon as practicable if the leave is not foreseeable.** Metromont reserves the right to deny or postpone your leave if adequate notice is not provided.

Employee Information

Name: (please print)	Employee #:
Job Title:	Location:
Supervisor:	Today's Date:

Reason for Requesting Leave

I am requesting leave for the following reasons: (check all that apply)

- Birth of my child; to care for my newborn child
- Placement of a child with me for adoption/foster care
- My own serious health condition
List medical condition: _____
- Leave to care for a family member with a serious health condition
Family member's full name: _____
Relationship to you: spouse parent son/daughter (give age:____) other
- Service-member care
- Exigency Leave
- Personal leave (non-medical)

Duration of Leave

Date leave is expected to begin: ____ / ____ / ____	Date I expect to return to work: ____ / ____ / ____
If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule: _____ _____	

Employee Certification and Signature

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave will result in denial of the leave and will subject me to disciplinary action, up to and including termination.

Signature: _____ Date: _____

**RETURN THIS COMPLETED FORM TO:
METROMONT BENEFITS DEPARTMENT, PO BOX 2486, GREENVILLE, SC 29602
FAX: (864) 295-5515**