

**FUTURES COMMUNITY SUPPORT SERVICES, INC.  
FAMILY MEDICAL LEAVE REQUEST FORM**

<b>Employee's Name:</b>	<b>Employee's Position:</b>  <b>Employee's Department:</b>
<b>Reason for requesting leave:</b> <ul style="list-style-type: none"> <li><input type="radio"/> Employee's own illness</li> <li><input type="radio"/> Birth of a child of the employee and in order to care for such child</li> <li><input type="radio"/> Placement of a child with employee for adoption or foster care</li> <li><input type="radio"/> In order to care for: <ul style="list-style-type: none"> <li><input type="checkbox"/> Spouse</li> <li><input type="checkbox"/> Child</li> <li><input type="checkbox"/> Parent</li> </ul> </li> </ul> <p>With a serious health condition</p>	<b>Date on which you wish to begin leave:</b>    <b>Date of anticipated return to work:</b>
Employee seeking leave because of spouse, child, or parents must provide medical certification within 15 days or as soon as practical.	Employees seeking to return to work after a leave because of their own serious illness must provide a medical certification of ability to perform job duties before they return to work.
<p>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 the Company for the cost of health benefits provided during my leave.</p> <p>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.</p>	
<b>Employee Signature:</b>	<b>Supervisor's Signature:</b>

**SUBMIT COMPLETED FORM TO THE HUMAN RESOURCES DEPARTMENT  
FOR ELIGIBILITY APPROVAL**