WASHOE COUNTY APPLICATION FOR FMLA
(Family and Medical Leave Act)

Employee Name: _____ Employee #: _____

Mailing Address and Phone #: _____

Department: _____ Work Tel. #: _____ Supervisor: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

I am requesting to take FMLA due to:
Check One:

_____ the birth of a child, or the placement of a child with you for adoption or foster care; or
_____ a serious health condition that makes you unable to perform the essential functions of your job
_____ a serious health condition affecting your □ spouse, □ child, □ parent, for which you are needed to provide care; or (check one)
_____ Worker's Compensation/On-the-Job Injury
_____ Military Caregiver Leave
_____ Qualifying Military Exigency

Reason for Leave (Explain):

_____
_____
_____
_____

LEAVE REQUESTED IN INCREMENTS OF:
_____ Weeks _____ Days _____ Intermittent

PAID OR UNPAID LEAVE:
Accrued annual, compensatory time, sick or personal leave will be used prior to unpaid leave time for any FMLA-qualifying purpose.

I hereby certify that I intend to return to work at Washoe County upon the completion of my FMLA Leave. I will notify my Department Head at least two (2) workdays prior to my intended return to work date.

Employee Signature: _____ Date: _____

ACKNOWLEDGED BY:

_____ _____
Immediate Supervisor Date

_____ _____
Department Head Date

_____ _____
Director of Human Resources or Designee Date

Related Links:

- Certification of Health Care Provider for Employee's Serious Health Condition
- Certification of Health Care Provider for Family Member's Serious Health Condition
- Certification of Qualifying Exigency for Military Family Leave
- Certification for Serious Injury or Illness of Current Servicemember -- for Military Family Leave
- Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave

DISTRIBUTION:
- Original sent to the Department of Human Resources
- Copies should be made for: Employee and Department

Authorization for Release of Health Information to Washoe County
(For FMLA - Family and Medical Leave Act Purposes Only)

I, _____ [Employee Name] hereby authorize the following healthcare provider to release to Washoe County the health information as stated below.
Health Information From:

Physician/Clinic/Healthcare Provider (name and address):

_____

_____

Phone: _____

Health Information About:
Patient Name: _____
Employee Name (if different from patient): _____

Purpose of Release: Leave requested under **FMLA** based on **health** condition of:
_____self _____child _____spouse _____ parent (*check one)*
Release to:

Washoe County
_____ (*insert name of Department Head*)

Address: _____

_____

Phone: (775) _____
Fax: (775) _____

Information to be released: Information is to be limited to reason employee is requesting leave under FMLA.

Expiration of Authorization: This **authorization** will expire one year from the date on which it is signed or when I am no longer requesting leave under **FMLA**, whichever is later.

Withdrawal of Authorization: I understand that I may withdraw or revoke this **authorization** at any time by giving written notice to my healthcare provider designated above. A withdrawal of this **authorization** will not apply to records/**information** already released in reliance upon the **authorization**.

Re-disclosure: I understand that once the above **information** is disclosed, it may be re-disclosed by the designated recipient and the **information** may no longer be protected by Federal privacy laws and regulations.

A photocopy or faxed copy of this signed **authorization** shall constitute a valid **authorization**.
I understand that the healthcare provider who is releasing this **information** to Washoe County will not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this **authorization**.

Signature of Employee: _____ Date: _____

Personal Representatives section
If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:

_____
_____
_____
_____

NOTE: This form is mandatory for employees requesting FMLA for a serious health condition. Failure to submit the Release of Health Information could delay your FMLA or cause your FMLA to be denied. The completion and submission of this Release of Health Information authorizes your attending physician to release all information requested on the Certification of Health Care Provider.