



## ARKANSAS DEPARTMENT OF FINANCE AND ADMINISTRATION REQUEST FOR FAMILY AND MEDICAL LEAVE

Agency/Institution Name		Date (MM/DD/YY)	
Employee Name (Last, First, Middle)			BEGIN FMLA: (MM/DD/YY)
Personnel Number	Business Area	Personnel Area	END FMLA: (MM/DD/YY)
Organization Unit	Job Title		Phone

Check all that apply:

- Yes  No I am requesting Family and Medical Leave (FMLA) for the days shown above.
- Yes  No I understand that FMLA, as federally mandated, is unpaid leave. However, all accrued paid leave, including Catastrophic Leave, must be exhausted before unpaid FMLA leave can be granted.
- Yes  No I understand that DFA may require a written second opinion from a health care provider at the expense of the state.
- Yes  No I understand that during FMLA, the agency/institution will continue paying the Employer portion of my group Health Plan, if I am a participant. I understand that I am responsible for paying the Employee's portion for the Health Plan for each pay Period. If I do not pay, my Health Plan may be cancelled after 30 days.
- Yes  No The Employee Benefits Division may contact my Health Care Provider for clarification/authenticity of my medical certification if required.
- Yes  No I am requesting unpaid FMLA.
- Yes  No I am requesting that my accrued leave (paid leave) be substituted for unpaid leave.

Employee's signature	Date (MM/DD/YY)
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**ACKNOWLEDGEMENT:**

Supervisor's signature	Date (MM/DD/YY)
Manager's signature	Date (MM/DD/YY)
Administrator's signature	Date (MM/DD/YY)