



State of Connecticut Human Resources  
**Employee Request**  
**For Medical Leave, Family Leave or Military Family Leave**  
*For information about specific leave entitlements, contact Human Resources*

(To be completed by Employee)

Form #: **FMLA-HR1**  
 Revision Effective Date: **1/1/22**

<b>Employee Name</b> _____	<b>Employee No.</b> _____
<b>Official Job Title</b> _____	<b>Agency</b> _____
<b>Supervisor</b> _____	<b>Supervisor Phone No.</b> _____
<b>Work Location</b> _____	<b>Shift</b> _____ <b>Hours</b> _____
<b>Home Address</b> _____	
<b>City</b> _____	<b>State</b> _____ <b>Zip Code</b> _____
<b>Employee's Personal Phone No.</b> _____	
<b>Employee's Personal Email</b> _____	

**REASON FOR LEAVE:** *(Check reason)*  
*For information about specific leave entitlements, contact Human Resources*

<p><b>Personal Medical Leave</b> (for your own serious health condition):</p> <p><input type="checkbox"/> My own illness or injury</p> <p><input type="checkbox"/> Disability period related to my pregnancy and childbirth</p> <p><input type="checkbox"/> Organ donation</p> <p><input type="checkbox"/> Bone marrow donation</p>	<p><b>Caregiver Leave</b> (care for family member in connection with the disability period related to pregnancy and childbirth, or organ or bone marrow donation, or other serious health condition):</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Parent</p> <p><input type="checkbox"/> Child Age of child _____</p> <p style="padding-left: 20px;">If the Child is age 18 or older, are they incapable of self-care due to a mental or physical disability as defined by the ADA?</p> <p style="padding-left: 40px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Spouse's parent <i>(State FMLA only)</i></p> <p><input type="checkbox"/> Sibling <i>(State FMLA only)</i></p> <p><input type="checkbox"/> Sibling-in-law <i>(State FMLA only)</i></p> <p><input type="checkbox"/> Grandparent <i>(State FMLA only)</i></p> <p><input type="checkbox"/> Spouse's grandparent <i>(State FMLA only)</i></p> <p><input type="checkbox"/> Grandchild <i>(State FMLA only)</i></p> <p><input type="checkbox"/> An individual related by blood or affinity whose close association with the employee is the equivalent to one of the above listed family relationships. <i>(State FMLA only)</i></p>
<p><b>Bonding Leave:</b></p> <p><input type="checkbox"/> Birth of child</p> <p><input type="checkbox"/> Adoption of child</p> <p><input type="checkbox"/> Placement of foster child <i>(Federal and state FMLA only)</i></p>	<p><b>Military Family Leave:</b></p> <p><input type="checkbox"/> Qualifying Exigency arising out of the covered active duty of my spouse, parent, or son or daughter</p> <p><input type="checkbox"/> Military Caregiver leave for my spouse, parent, son, daughter or next of kin who is a covered servicemember</p> <p><input type="checkbox"/> Military Caregiver leave for my spouse, parent, son, daughter or next of kin who is a covered veteran <i>(Federal FMLA only)</i></p>

Does your spouse work for the State? \_\_\_\_\_ (yes) or \_\_\_\_\_ (no)  
If YES: Spouse's Name: \_\_\_\_\_ Spouse's Agency: \_\_\_\_\_

Will your spouse be taking leave for the same purpose? \_\_\_\_\_ (yes) \_\_\_\_\_ (no)

**TYPE OF LEAVE REQUESTED:** (Check all that apply)

- Block Leave:** A continuous absence for a single qualifying reason (e.g., one month).
- Reduced Schedule Leave:** A leave schedule that changes the employee's normal work schedule for a period of time by reducing the employee's usual number of working hours per workweek or hours per day.
- Intermittent Leave:** Leave taken in separate blocks of time due to a single qualifying reason.

**NOTE:**

Intermittent leave and reduced schedule leave are not available in all situations. Availability of these types of leave depends upon the reason for leave and your eligibility for specific leave entitlements. Contact Human Resources for more information.

**Duration of Leave:** (from) \_\_\_\_\_ (to) \_\_\_\_\_  
(month/day/year) (month/day/year)

Please describe your leave request:

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**REQUESTED USE OF ACCRUALS:**

- The choice to use your accruals during your absence must be made before you begin your leave.
  - If you want to change your accrual designation, you must contact Human Resources.
  - Accrual changes will be applied prospectively.
- If the reason is for your own personal medical leave:
  - Sick leave accruals must be used.
  - Sick leave accruals must be exhausted before other earned accruals can be used.
  - Under State FMLA, you may retain two weeks of accrued leave.. If you do not have at least two weeks of accrued leave other than sick, you may retain the number of sick leave days that when combined with your other non-sick accrued leave time equals two weeks.
- If you do not elect to use your accruals, the leave will be unpaid.
- If you choose not to use all of your accruals or if your accruals are exhausted before the leave ends, the remainder of the leave will be unpaid.
- If you elect to use your accruals, that paid time must be spent down completely before you go into unpaid status.
- You cannot intermingle unpaid time with paid time.
- Depending upon the reason for leave and your eligibility for specific leave entitlements, you may be allowed to use sick leave accruals for leave associated with bonding with a newborn child or newly placed adoptive child and for caregiver leave. Human Resources will notify you if you meet the criteria for use of sick leave accruals for these reasons.

**Fill In Chart:** You must designate the number of days, or hours, or you may indicate “ALL available.”

<b>USE OF ACCRUALS</b>	<b>Sick Leave Accruals</b>	<b>Vacation Accruals</b>	<b>Personal Leave</b>	<b>Comp Time</b>	<b>Sick Family Days (based on bargaining unit contract)</b>	<b>Parental Days (based on bargaining unit contract)</b>
<b>REASON</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>
<b>PERSONAL MEDICAL LEAVE</b>						
My own illness or injury					Not Applicable	Not Applicable
Disability period related to my pregnancy & childbirth					Not Applicable	Not Applicable
Organ donation (after exhaustion of paid leave entitlement of 15 days)					Not Applicable	Not Applicable
Bone marrow donation (after exhaustion of paid leave entitlement of 7 days)					Not Applicable	Not Applicable
<b>CAREGIVER LEAVE</b>						
Spouse (including providing care to your wife during the disability period associated pregnancy and childbirth)						Not Applicable
Parent						Not Applicable
Parent-in-law					Not Applicable	Not Applicable
Child						Not Applicable
Sibling						Not Applicable
Sibling-in-law					Not Applicable	Not Applicable
Grandparent					Not Applicable	Not Applicable
Spouse’s Grandparent					Not Applicable	Not Applicable
Grandchild					Not Applicable	Not Applicable
An individual related by blood or affinity is equivalent to a “family member”					Not Applicable	Not Applicable

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<b>REASON</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>	<b>Days/Hours &amp; Priority #</b>
<b>BONDING LEAVE</b>						
Birth of child					Not Applicable <i>(unless child is sick)</i>	
Adoption of child					Not Applicable <i>(unless child is sick)</i>	
Placement of foster child					Not Applicable <i>(unless child is sick)</i>	Not Applicable
<b>MILITARY FAMILY LEAVE</b>						
Military Caregiver - Covered Servicemember						Not Applicable
Military Caregiver - Covered Veteran						Not Applicable
Qualifying Exigency leave					Not Applicable	Not Applicable

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Date)

**Return the completed form(s) to Human Resources.**