STATE OF IOWA

**Servicemember Family Leave**

# Application

***TO BE COMPLETED BY EMPLOYEE AND PERSONNEL ASSISTANT (please print or type)***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name: | | |  |  | SSN: |  | | |
|  | | |  |  |  |  | | |
| Department: |  | | |  | Payroll No.: | | |  |
|  |  | | |  |  | | |  |
| Bargaining Unit: | |  | |  | Status: | |  | |
|  | | | | | | |  | |

|  |
| --- |
| My spouse is employed by the State of Iowa (check one):  Yes  No If yes, name the department and verify the number of FMLA hours used during fiscal year (if any): |

**PERIOD OF SERVICEMEMBER LEAVE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FROM:** |  |  | **TO:** |  |
|  | *(Date - must be included to process your application)* |  |  | *(Date - if known, indicate if unknown)* |

**CHECK THE APPROPRIATE BOX:**

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| --- |
| **CARE OF A COVERED SERVICEMEMBER (26 WEEK MAXIMUM)** |
| (Servicemember’s serious health condition) |

|  |  |  |  |
| --- | --- | --- | --- |
| Servicemember Name: |  | Relationship: |  |

|  |
| --- |
| **QUALIFYING EXIGENCY LEAVE (12 WEEK MAXIMUM PER FISCAL YEAR)** |

|  |  |  |  |
| --- | --- | --- | --- |
| Servicemember Name: |  | Relationship: |  |

|  |  |
| --- | --- |
| Reason for Leave: |  |

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| **Certification of physician or practitioner must accompany this form, except in the case of a qualifying exigency. However, completion of this form is required. You may be required to supply further documentation.** |
|  |
| ***I understand that during Servicemember Family Leave, I am required to pay my share of insurance premiums for which I am ordinarily responsible. If premiums are not paid within 30 calendar days of the coverage month, my insurance will be retroactively canceled.***  ***I acknowledge that, if I do not return from leave due to reasons not provided in the Family and Medical Leave Act, I am required to reimburse any premiums paid by the State of Iowa for my insurance while I am on approved Servicemember Family Leave. If reimbursement is not made, insurance coverage will be canceled retroactively to the first of the month following exhaustion of paid leave.*** |

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| --- |
| I intend to return to work (check one):  Yes  No  Unknown |

**Your signature certifies that you have read and understand the information on this form.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Employee Signature: |  | | |  | Date: |  |
|  | | | | | | |
| Supervisor Approval: |  | | |  | Date: |  |
|  | | | | | | |
| Personnel Assistant Verification: | |  | |  | Date: |  |
|  | | | | | | |
| Personnel Assistant Telephone Number: | | | (     ) | | | |

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | |
| **EXTENSION of Request (if maximum leave per fiscal year is not exhausted). Additional Information May Be Required:** | | | | | | |
|  | | | | | | |
| **From:** |  | |  | **To:** |  | |
|  | *(Date)* | |  |  | *(Date)* | |
| Employee Signature: | |  |  | Date: | |  |
|  | |  |  |  | |  |
| The employee named is granted the extension of Servicemember Family Leave requested. All stated information remains accurate. | | | | | | |
|  | |  |  |  | |  |
| Supervisor Signature: | |  |  | Date: | |  |

# TRACKING

***To be completed by the personnel assistant (please print or type)***

|  |  |  |
| --- | --- | --- |
| 1. | FMLA leave used to date: |  |
|  | *(If employee has previously been approved for FMLA leave during the current fiscal year, enter the number of hours previously utilized [from (6)*  *on last FMLA leave tracking form].)* | |

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| --- | --- | --- | --- | --- | --- |
| 2. | Last date worked: |  |  | 2a. FMLA start date: |  |
|  | *(Enter the last date the employee was actively working and the date FMLA leave started.)* | | | | |

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| --- | --- | --- | --- | --- | --- |
| 3. | Last date in paid status: |  |  | 3a. Hours of paid FMLA leave: |  |
|  | *(Enter the last date the employee was in pay status [if applicable] and the total hours of paid FMLA leave.)* | | | | |

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| 4. | Returned to work: |  |  | 4a. Hours of unpaid FMLA leave: |  |
|  | *(When employee returns from leave enter the date returned [if applicable].) (Enter the total hours of unpaid FMLA leave [if applicable]).* | | | | |

|  |  |  |
| --- | --- | --- |
| 5. | FMLA leave expired: |  |
|  | *(If the employee did not exhaust the 12 week maximum, go to number six. If the employee did exhaust the 12 week maximum, enter the date*  *and hour in which it terminated [see calculation worksheet below to determine the maximum number of hours available per fiscal year].)* | |

|  |  |  |
| --- | --- | --- |
| 6. | Total FMLA leave used: |  |
|  | *(Enter the total number of FMLA leave hours [paid and unpaid] used this fiscal year.)* | |

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| --- | --- | --- | --- | --- | --- |
|  |  | X | 12 | = |  |
|  | *(Average Number of Hours Per Week)* |  | *(weeks)* |  | *(Total Number of FMLA Leave Hours Available)* |

|  |
| --- |
| **NOTE:** If average number of hours per week is under 30, the employee is not eligible for life and disability insurance. If average number  of hours per week is under 20, the employee is not eligible for health and dental insurance. |

PLEASE USE THE TABLE BELOW TO TRACK FMLA LEAVE USAGE

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pay Period |  | Hours Worked |  | FMLA Leave UsedThis Pay Period |  | **FMLA Leave Used** This Fiscal Year |
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