FAMILY AND MEDICAL LEAVE ACT (FMLA) **EMPLOYMENT INFORMATIOM FORM** **FOR INTERNAL D. O. L. STAFF ONLY**	**DATE**
(ELIGIBLE) EMPLOYEE INFORMATION	
NAME **MR ☐ MS ☐**	**PHONE:** **HOME** **WORK**
ADDRESS **CITY**	**STATE AND ZIP CODE**
CURRENT EE ☐ FORMER EE ☐ OTHER EXPLAIN	
EMPLOYMENT INFORMATION	
TITLE / POSITION	**RATE OF PAY _____PER_____** **LENGTH OF PERIOD_____**
HEALTH INSURANCE YES ☐ NO ☐ **PREMIUM AMOUNT _____** **PREMIUM FREQUENCY _____** **PERIOD EMPLOYED FROM _____** **TO _____**	**OTHER BENEFITS, TERMS, CONDITIONS**
TOTAL OF 12 MONTHS OR MORE YES ☐ NO ☐ **TOTAL OF 1250 HOURS OR MORE YES ☐ NO ☐** **(OVER PREVIOUS 12 MONTHS (MUST AVERAGE 24 HRS X 52 WKS FOR AT LEAST 1250 HRS))** **IS COLLECTIVE BARGAINING AGREEMENT IN EFFECT YES ☐ NO ☐** **PAID ON SALARY BASIS YES ☐ NO ☐** **AMONG 10% OF HIGHEST PAID EEs YES ☐ NO ☐** **TEACHER AT PRIMARY / SECONDARY SCHOOL YES ☐ NO ☐**	**FMLA ENTITLEMENT** ☐ **CHILD BIRTH** ☐ **CARE FOR SPOUSE / CHILD OR PARENT WITH SHC*** ***SHC-SERIOUS HEALTH CONDITION (MUST BE MORE THAN 3 DAYS OR UNLESS CHRONIC OR LONG TERM TREATMENT)**
(COVERED) EMPLOYER INFORMATION	
ESTABLISHMENT NAME	**CONTACT PERSON / TITLE**
ADDRESS	**PHONE** **FAX #**
CITY / STATE / ZIP CODE	**COUNTY**
MAIN OFFICE (LEGAL INDENTITY & ADDRESS)	
BRANCHES (WITHIN 75 MILES) LIST HERE	
STATE OR LOCAL GOVERNMENT YES ☐ NO ☐ **TOTAL EEs AT WORKSITE_____** **(AT LEAST 50 EEs IN 20 CALENDAR WK / WKS)**	**TYPE OF BUSINESS**
DATE LEAVE REQUESTED **FORSEEABLE ☐ UNFORSEEABLE ☐**	
PERSON NOTIFIED AND METHOD (SUCH AS BY PHONE)	
BEGINNING DATE OF REQUESTED LEAVE (IF INTERMITTENT LIST DATES AND REASONS)	
LENTH OF LEAVE REQUESTED: (FROM) _____(TO)_____	

HAS ER PROVIDED WRITTEN NOTICE OF FMLA RIGHTS **YES ☐ NO ☐**

ARE FMLA RIGHS POSTED AT THE ESTABLISHMENT **YES ☐ NO ☐**

PRIOR TO CURRENT EVENT WAS FMLA USED IN PRECEDING 12 MONTHS **YES ☐ NO ☐**

IF "YES" PROVIDE DATES FROM_____TO_____

IF THERE IS A CBA HVE YOU FILED A GRIEVANCE **YES ☐ NO ☐**

IF "YES" NAME _____PHONE #_____

DATE CONTACTED REPRESENTATION_____
_____

NATURE OF VILATION

REMARKS – I BELIEVE MY ER VIOLATED THE FMLA BECAUSE

REMEDIES SOUGHT BY EMPLOYEE _____
_____
_____
_____
_____
_____
_____
_____

I AUTHORIZE A WAGE & HOUR REPRESENTATIVE TO USE MY NAME AND INFORMATION I HAVE PROVIDED

_____

AUTHORIZATION PROVIDED BY PHONE ☐ MAIL ☐ IN PERSON ☐

COMPLAINT TAKEN BY:	