REVISED MONMOUTH COUNTY - Family & Medical Leave Request

FML

Section 1

Last Name	**First Name**	**Employee ID #**
Address	☐ Check box if this is a new address	
City	**State**	**Zip**
Email	**Phone**	**DOB**

Section 2

Is this request for a FML Qualifying Reason?

1. Birth of a child? Date of the child's birth _____ ☐ Yes ☐ No
   Baby Bonding Leave ☐ Yes ☐ No
   - Each instance of bonding requires notice to your employer.
     - o 15 days' notice is required for intermittent leave
     - o 30 days' notice is required for block leave.
   - Proof of Birth
2. Placement of child for adoption? ☐ Yes ☐ No
3. Placement of child for foster care? ☐ Yes ☐ No
4. School Closure due to COVID-19 ☐ Yes ☐ No
5. Care of a family member? ☐ Yes ☐ No
6. Qualifying Exigency for Military Leave ☐ Yes ☐ No
   - Military Service Orders attached ☐ Yes ☐ No
7. Serious Health Condition of Covered Service Member – for Military Family Member ☐ Yes ☐ No
8. Serious Health Condition (The employee's own condition that prevents him/her from performing the essential function of his/her job, or the care of employee's spouse, child, or parent) involving one of the following:
   a. Inpatient Care, period of incapacity and subsequent treatment related to same? ☐ Yes ☐ No
   b. Incapacity of more than 3 calendar days with treatment 2 or more times? ☐ Yes ☐ No
   c. Incapacity of more than 3 calendar days with one treatment resulting in therapy or prescription? ☐ Yes ☐ No
   d. Prenatal care or incapacity due to pregnancy? ☐ Yes ☐ No
   e. Incapacity (or treatment) due to chronic serious health condition? ☐ Yes ☐ No
   f. Incapacity, permanent or long term, for which treatment may not be effective? ☐ Yes ☐ No
   g. Absence for multiple treatments for restorative surgery, radiation, physical therapy, etc. ☐ Yes ☐ No

If NO to all of the above, Form WH-382 will be sent to notify you that you are ineligible for FMLA.

If YES to any question in section 2, complete section 3, questions 2-6 below:

Section 3

Has Medical Certification Been Submitted to IAA? ☐ Yes ☐ No

If not already received, IAA will request employee to submit medical documentation for the medical leave.

Leave Request Dates

Leave Beginning: _____ Leave Ending: _____ Last Day Worked: _____

Is this leave request for Intermittent Leave? ☐ Yes ☐ No

If yes, appointment verifications must be submitted to your department heads/designee for each physicians visit.
All medical documentation should be submitted directly to IAA.

List all paid time you would like to utilize for this leave if applicable.

In most cases you are required to use all available accrued sick and personal leave as part of your FML. Some leaves may require the use of other available paid time off. Additional paid leave (if available) can be utilized once the required paid leave is exhausted. Please specify additional paid time you would like to use:

Sick: Hours _____ / Days _____ **Vacation:** Hours _____ / Days _____

Other: Hours _____ / Days _____ **Personal:** Hours _____ / Days _____

Fraud Warning: Filing a claim with materially false and/or misleading information is a crime and may be subject to criminal charges in addition to disciplinary action up to and including termination from employment with the County of Monmouth.

Submit Forms to Insurance Administrator of America, Inc.
Fax: 856-528-2123; Alt. Fax: 800-220-8503 ~ Email: fmla@iaatpa.com
Mail: IAA-FMLA 1934 Olney Ave. Suite 200 Cherry Hill, NJ 08003

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