

Dear  Employee:

Enclosed is a Family and Medical Leave Act (FMLA) Request Form which should be completed in its entirety.

The following conditions may apply to your leave status:

1. Leave for reasons of childbirth or child placement cannot be used intermittently.
2. If you are requesting leave status due to your own serious illness, to the maximum extent allowed by law, you must use all paid sick days prior to taking any unpaid leave days.
3. If you are requesting leave status for an immediate family member with a serious health condition, birth or placement for adoption or foster care of a child, to the maximum extent allowed by law, all accrued vacation days and/or personal days **may** be used prior to taking any unpaid leave days.
4. Leave taken intermittently must be scheduled at least 30 days in advance except in the case of an emergency. A schedule of the days to be used must be given to your supervisor. Documentation supporting the emergency must be provided within 15 days of the event.
5. If your leave is going to be 30 or more consecutive unpaid days, you must contact the People Department in advance to ensure continuation of your benefits.

The completed FMLA Request Form must be returned to your Supervisor and/or Department Head at least 30 days in advance of the requested start of your leave unless that is impracticable, in which case you must contact your Supervisor and/or Department Head at your earliest opportunity.

MEDICAL INFORMATION SUPPORTING YOUR LEAVE REQUEST MUST BE SENT TO:

CN MEDICAL SERVICES

17641 S. Ashland
Homewood, IL 60430.

Fax: (708) 332-4349

If you have any questions, please call (708) 332-3576.



Family and Medical Leave Act (FMLA) Request Form

Name: _____ PIN: _____ Date: _____

Address: _____

Department: _____ Position/Job Title: _____

Supervisor's Name: _____ Work Location: _____

I, _____, request a leave of absence for the following reason: (check one):

The birth of my son or daughter and to care for such child

Name of Child: _____ Date of Birth: _____

The placement of a son or daughter with me for adoption or foster care

Name of Child: _____ Date of Placement: _____

Serious health condition of:

Self

Spouse Name: _____

Child Name: _____

Parent Name: _____

Parent-in-law Name: _____
(Wisconsin)

Schedule of Leave

I will be absent from work from _____ to _____

OR

On the following dates _____

OR

Intermittently



Family and Medical Leave Act (FMLA) Request Form

Health Care Provider Certification

If your leave request is due to a serious health condition, please have a Certification of Health Care Provider form completed by a Health Care Provider. I understand that the Certification of Health Care Provider form should be returned to CN Medical Services within fifteen (15) days after receiving the form. If I am not able to return the form within fifteen (15) days, I will contact CN Medical Services before the fifteen (15) days have passed and request assistance.

Attending Health Care Provider:

Name: _____ Telephone Number: _____

Address: _____

By the execution of this request form, I hereby authorize the Health Care Provider listed above to provide such information to the company as its agent may request relative to the information required in the Certification of Health Care Provider form of the company without liability for the release of such information, I understand a separate consent may be necessary if the certification is for my spouse or parent.

Medical Certification

I understand that if I am requesting medical leave for my serious health condition or the serious health condition of my spouse, parent, parent-in-law, son or daughter, I must provide the company with a Certification of Health Care Provider form. While I am on leave, I understand I must provide the company with updates on my intent to return on a periodic basis. If the medical leave was due to my own serious health condition, I must also provide the company with a fitness for duty certification before my return to work. I understand that my failure to provide this certification may result in my being denied reinstatement until such certification is provided to the company.

In the event that I desire to return to work prior to the expiration of my leave, I will notify the company at least one (1) working day prior to my desired return date. If I return early, the company will attempt to place me in my former position or an equivalent position until the expiration of the time of my initial leave.



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Premium Payments and Recovery

I understand and agree that if I elect to continue health insurance coverage that I will pay such amounts while I am on leave consistent with my present payment schedule. If I fail to return to work at the expiration of my leave, the company may recover its share of premiums paid to maintain the coverage.

Substitution of Leave

If I am taking leave for the birth or placement for adoption or foster care of my son or daughter, or the serious health condition of my son, daughter, spouse, parent or parent-in-law, I understand I **may** use any accrued vacation or other paid leave along with the time taken for the unpaid family and medical leave.

If I am taking leave for my own serious health condition, I understand the company will require me to use any accrued sick days along with the time taken for the unpaid family and medical leave.

I understand that the use of any accrued leave for my family and medical leave will not extend or result in additional family and medical leave being available to me. The family and medical leave will run concurrently with any leave used.

If I have any questions or require the forms necessary to comply with the requirements of the company's Family and Medical Leave Policy, I must contact CN Medical Services.

Signature: _____ Date: _____

Supervisor: _____ Date: _____