Human Resources
1769 E. Moody Blvd Bldg 2
Bunnell, FL 32110

www.flaglercounty.org
Phone: (386)313-4020
Fax: (386)313-4120

APPLICATION FOR FAMILY OR MEDICAL LEAVE

Name: ____

Department: ____

Current Address: ____

Phone: ________________________

Start Date of Leave: __________________________________

Expected Date of Return to Work: ________________________

Reason for Leave:____

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Note: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

I hereby authorize the County to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the County. I further understand that I will not be guaranteed reinstatement if I am out greater than 12 weeks.

____ ________________________
Employee Signature Date

____ ________________________
Director Signature Date