Please complete the following information fully and completely. Several questions below seek a response

not be sufficient to determine Family Medical Leave Act (FMLA) coverage. Your response is required to obtain a benefit. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. You must provide this form to your employer within 15 calendar days after you have notified your employer of the need for leave.

First	Middle	Last		

		th lasting 4 hours):	pointment, meeting,	or leave event, ir	iciuding any travei tir	ne (i.e., il depioyi
Frequency:	times per	week(s)	month(s)			
Duration:	hours	day(s) per event				
of Individual:			Title:			
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none: <u>()</u>			Fax: (<u>)</u> _			
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I certify that the information I provided above is true and correct.