



## CITY OF CAMDEN F.M.L.A LEAVE REQUEST

**TO:** Jason J. Asuncion, Esq., Business Administrator

**FROM:**

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Home Phone:

\_\_\_\_\_  
Cell Phone:

\_\_\_\_\_  
E-Mail Address:

\_\_\_\_\_  
Department:

\_\_\_\_\_  
Title:

I respectfully request a leave of absence  with  without pay for under the provision of the Family and Medical Leave Act. I am requesting the leave for the following reason(s):

The Birth of a child, placement of a child for adoption or foster care.

A serious health condition affecting my:

Spouse

Child

Parent

Next of Kin (Only for Military FMLA)

A Personal Health Condition

*(Request for yourself, family member or next of kin must be accompanied by a Certification of Health Care Provider)*

**\*Continuous**

Start Date: \_\_\_\_\_

Expected End Date: \_\_\_\_\_

**\*Intermittent** (Leave taken in separate block of time)

Start Date: \_\_\_\_\_

Expected End Date: \_\_\_\_\_

**Reduced** (Leave taken that reduces the usual number of working hours per week or hours per day)

Usual Bi-weekly hours: \_\_\_\_\_  Reduced Bi-weekly hours: \_\_\_\_\_

Start Date: \_\_\_\_\_ Expected End Date: \_\_\_\_\_

**Pursuant to Fact Sheet #20 of the State of New Jersey:**

**FAMILY LEAVE:** State and Local employees enrolled in the SHBP or SEHBP are entitled to health benefits coverage continued at the expense of their employer while they are on federal and/or State family leave. **The member is responsible for paying normally required premium payment or health benefits contribution to the employer, in advance of the leave.**

\_\_\_\_\_  
Signature Date

Approved

\_\_\_\_\_  
Business Administrator Date

Disapproved

C: Personnel File

**\*USE OF VACATION/HOLIDAY TIME FOR LEAVE OF ABSENCE IS SUBJECT TO DEPARTMENTAL POLICIES AND PROCEDURES.**