



**Douglas County, Nebraska  
EMPLOYEE APPLICATION  
FAMILY AND MEDICAL LEAVE ACT**

Name: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Department: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Last 4 digits of Social Security Number: \_\_\_\_\_

I request a family and medical leave of absence for the reason indicated below (check box that applies):

- Because of my own serious health condition which makes me unable to perform the functions of my job
- For the birth of my son or daughter and to care for the newborn child (anticipated delivery date: \_\_\_\_\_)
- For placement with me of a child for adoption or foster care
- To care for my spouse, son, daughter, or parent with a serious health condition

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

If son or daughter, date of his/her birth (mm/dd/yyyy): \_\_\_\_\_

- To care for my spouse, son, daughter, parent, or relative to whom I am the next of kin who has an illness or injury incurred during active military duty

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

- Because my spouse, son, daughter, or parent who is currently on or is being called to active military duty

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

My leave will be (check box that applies):

- Consecutive leave beginning (mm/dd/yyyy) \_\_\_\_\_ and continuing to \_\_\_\_\_
- Intermittent/reduced schedule beginning (mm/dd/yyyy) \_\_\_\_\_ and continuing to \_\_\_\_\_

According to the following schedule: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Complete only if you are providing care to a family member**

State the care you will provide and an estimate of the period during which care will be provided. Use additional paper if necessary. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your spouse work for the County?  Yes  No If yes, please provide the following information:

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

In addition to paid sick leave (if applicable), I request to use the following leave (check all boxes that apply):

- Vacation      Number of hours needed: \_\_\_\_\_
- Comp Time      Number of hours needed: \_\_\_\_\_
- Unpaid leave      Number of hours needed: \_\_\_\_\_
- Floating Holiday      Number of hours needed: \_\_\_\_\_

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I understand that after all requested paid leave is exhausted; any remaining leave will be without pay.

I understand that my leave may be delayed until the Medical Certification Form (which must be returned within 15 days) is returned if applicable.

I understand that in the case of my own serious health condition, I may not be permitted to resume my position with the County until I provide a completed "Return to Work Release" form.

I understand that if I do not return to work on the date indicated above (or another date as specified by me and agreed to by my supervisor), my employment may be terminated by the County as of the date my leave expires.

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Employee Signature

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Date

**Employee: Submit this form to your supervisor or designee**