APPLICATION FOR FAMILY AND MEDICAL LEAVE

Please reference: WH1420a Revised 04/16 – the FMLA Poster

Name: _____ **Title:** _____
Department: _____
Current Address: _____
Date Leave Began or is Anticipated to Begin: ____/_____/_____
Expected Date of Return: ____/_____/_____

My reason for Family and Medical Leave is:

☐ incapacity due to pregnancy, prenatal medical care or child birth;
☐ to care for the my child after birth, or placement for adoption or foster care;
☐ for the care of a serious health condition that makes me unable to perform my job;
☐ to care for my ☐Spouse ☐Son, ☐Daughter or ☐Parent, who has a serious health condition; or
☐ Military- Exigency/Caregiver leave: _____.

As per AMERISAFE policy, determination of the 12-month period in which the 12 weeks of leave entitlement occurs is based upon a ``rolling'' 12-month period measured backward from the date an employee uses any FMLA leave.

Under the Family and Medical Leave Act, if you have worked for this Company at least one year and at least 1,250 hours in the past 12 months, you are eligible for up to 12 weeks unpaid leave in a 12 month period under specific circumstances. You are entitled to receive health benefits as if you were still working. When returning to work, you must be reinstated to the same or an equivalent job with the same pay, benefits and terms and conditions of employment. If you do not return to work following Family and Medical Leave Act Leave (for a reason other than the continuation, recurrence or onset of a serious health condition which would entitle you to further Family and Medical Leave Act leave or circumstances beyond your control), you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your Family and Medical Leave Act Leave. If you do not return to work upon the expiration of your 12 week entitlement under the Family and Medical Leave Act (or 26 week entitlement of leave to care for a covered service member) during a single 12-month period, your job will no longer be protected under the Family and Medical Leave Act.

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 Health Care Provider Certification.

I hereby authorize AMERISAFE to contact my health care provider to verify the reason for my requested leave or for any other information concerning my requested Family and Medical Leave. I understand however, that it remains my responsibility to obtain and forward to my employer the required Health Care Provider's Certification.

I understand that the 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.

I understand that my restoration to employment is subject to the following conditions:

1. Prior to returning to work, I must provide the Benefits Department written certification from my health care provider confirming my ability to resume working. The certification should include any applicable restrictions related to my work activities and duties.

2. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

3. An employee returning from Family and Medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave however, the use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Signature: _____Date:_____

Supervisor Signature: _____Date:_____

*This form may be completed and submitted on behalf of an employee.