

<b>CHAPTER:</b>	<b>6 - LEAVE TIME</b>	<b>ADOPTED: 3/7/06</b>
<b>SECTION:</b>	<b>11 - UNPAID LEAVE</b>	<b>REVISED:</b>

**EXHIBIT S–FAMILY/MEDICAL LEAVE NOTIFICATION**

(NOTE: All Family and Medical Leave requests are subject to the conditions set forth in HR 6.11 Exhibit R titled “Family and Medical Leaves of Absence”)

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

Title \_\_\_\_\_ Date of Hire \_\_\_\_\_

Under the provisions of the New Jersey Family Leave Act (NJFLA), NJSA 34:11B-1 et seq. and/or the federal Family and Medical Leave Act (FMLA):

- (1) I am requesting leave (accrued, as applicable, and/or unpaid)
- (2) During the twelve (12) months immediately preceding this request, I have worked for the County over 1,000 hours, exclusive of overtime (NJFLA) and/or at least 12 months (which need not be consecutive) for the County and worked at least 1,250 hours during the 12 months preceding the leave (FMLA).

(3) The reason for my leave is: (Check one)

- The birth or the placement of a child for adoption or foster care;
- To care for a family member who has a serious health condition.

Name of family member and relationship to you:

\_\_\_\_\_.

- A serious health condition that I need care for.

(4) I expect the leave to begin on or about \_\_\_\_\_.

I expect to return to work on or about \_\_\_\_\_.

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(Check one of the following if it is applicable to you)

- I am requesting a reduced leave schedule (attach proposed schedule to this request).
- I am requesting an intermittent leave schedule (attach proposed schedule and supporting medical documentation to this request).

(5) My leave is: (Check one)

- due to the birth or adoption of a child and I will provide a medical certificate from a health care provider which will include the date of birth or placement of the child.
- due to the serious health condition of a family member and I will provide the County with a medical certificate from health care provider (within 14 days) which will include:
  - (a) the date on which the medical condition began;
  - (b) the probable duration of the condition;
  - (c) the medical facts within the health care provider's knowledge regarding the condition.

(6) I am not presently working over twenty (20) hours, including overtime, per week for any employer other than the County.

(7) I realize that I may not work over twenty (20) hours, including overtime, per week for any other employer while I am on leave from my position with the County.

NOTE: If you are not presently working full-time for an employer other than the County, under certain conditions, you may not do so during your leave.

(8) During my leave, the County will continue to provide my health insurance benefits (For example, major medical, hospitalization, dental, prescription and vision). If any premium or payments need to be made by me, I understand and agree to make such payments. If I fail to make such payments, I understand that the County may cancel my health insurance benefits. Other insurance benefits (for example, disability insurance, group life insurance) will only be continued until the end of the month in which my leave begins.

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(9) I have read, understand, and agree to comply with the attached General Information Section and certify that I have been provided with a copy of both the General Information Section and this application.

(10) I realize that failure to sign this certification may result in my being denied this leave.

I certify that the foregoing statements are true to the best of my knowledge and belief. If any of them are willfully or knowingly false, I may be subject to disciplinary action.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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Approved [  ]      Disapproved [  ]

By: \_\_\_\_\_

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

cc:    Human Resources Director  
      Employee's Personnel File