**PAID FAMILY LEAVE – REQUEST**

# Part A. To be completed by employee or designee

## **Section 1. Employee Information**

Employee’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID #: \_\_\_\_\_\_\_\_\_\_\_\_

*(Last) (First) (MI)*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Class title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full-time:  Part-time:

Agency name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Budget acct. #: \_\_\_\_\_\_\_\_\_ Position Control #: \_\_\_\_\_\_\_\_\_

## **Section 2. Leave Dates (Continuous/Intermittent)**

Estimated leave start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estimated date of return: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leave is requested on an intermittent basis. Indicate the anticipated days/dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## **Section 3. Reason for Leave**

Bond with a newborn child

Bond with newly adopted child

Recover from or undergo treatment for a serious illness

Care for your seriously ill immediate family member:  parent /  sibling /  child by blood, adoption or marriage /  spouse /  grandparent /  grandchild.

Immediate family member’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participate in a qualifying event resulting from the military deployment to a foreign country of an immediate family member:  parent /  sibling /  child by blood, adoption or marriage /  spouse /  grandparent /  grandchild.

Immediate family member’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Section 4. Documentation**

If applicable, medical certificate is attached. (Form HR-17 or HR-18)

If applicable, documentation to establish required relationship between employee and covered individual attached.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of employee or designee) (Date)

**PAID FAMILY LEAVE – REQUEST**

# Part B. To be completed by human resources/appointing authority

Employee meets eligibility requirements for paid family leave.

Employee does NOT meet eligibility requirements for paid family leave.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of appointing authority or designee) (Date)

For information on the provisions of Paid Family Leave, see the [HR Reference Guide](https://hr.nv.gov/Resources/Publications/HR123/HR_1-2-3_Topics/).