



The Arc Mercer, Inc.

Family and Medical Leave Act (FMLA)
Employee Election Form

PART A: EMPLOYEE INFORMATION

Name: \_\_\_\_\_ Employee #: \_\_\_\_\_

Position: \_\_\_\_\_ Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

PART B: REQUESTED LEAVE DATES

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

Expected Return Date: \_\_\_\_\_

PART C: REASON FOR LEAVE

I request leave under the Family and Medical Leave Act for the following reason
(Select all that apply)

- o Because of the birth of my child
o Because of the placement of a child with me for adoption or foster care
o In order to care for my spouse, child, or parent, who has a serious health condition.
o For a serious health condition that makes me unable to perform my job duties for three consecutive days or more.
o For a serious health condition with flare-ups that makes me unable to perform my job duties episodically.

PART D: PAYMENTS DURING LEAVE

After using all available sick time, I elect the following:

- o Use any accrued vacation time available.
o Continue leave as unpaid (I may apply for State of New Jersey Disability)

PART E: CERTIFICATION

I, the undersigned, understand the policies of The Arc Mercer and the United States Department of Labor relating to the Family and Medical Leave Act (FMLA). I further understand that I am required to submit necessary documentation to substantiate this request for leave, and may be required to submit recertification and clearance to return to work at my employer's request. I understand that FMLA entitles me to a period of leave not to exceed 480 hours in a twelve-month period beginning on the first day of my FMLA leave, and that upon my return, I am guaranteed to have a position of similar nature, similar hours, and the same pay rate. Should I elect to remain on leave for a period longer than 480 combined hours in the twelve-month period, beginning on the first day of my FMLA leave, I understand that there will be no guarantee of continued employment, and that any termination of my employment would be considered voluntary.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

Please return this form to the Human Resources Department

HR USE ONLY

\_\_\_\_\_  
Director of Human Resources

\_\_\_\_\_  
Date