U.S. Department of State

FAMILY AND MEDICAL LEAVE ACT (FMLA)
(SEE 3 FAM 3530)

1. Name	2. Grade
3. Position Title	4. Bureau/Office or Post
5. Telephone Number (*Personal and Work*)	6. E-Mail Addresses (*Personal and Work*)

7. I invoke the FMLA for the following reasons. *(check one of the following)*

- ☐ a. The birth of a son or daughter of the employee and the care of such son or daughter.
- ☐ b. The placement of a son or daughter with the employee for adoption or foster care and the care of such son or daughter.
- ☐ c. The care of a spouse, son, daughter, or parent of the employee with a serious health condition.
- ☐ d. A serious health condition of the employee that makes the employee unable to perform any one or more of the essential functions of his or her position.
- ☐ e. A qualifying military exigency as outlined in 3 FAM 3530.
- ☐ f. Care of a covered servicemember as outlined in 3 FAM 3530.

8a. My FMLA period begins on *(mm-dd-yyyy)*	8b. My FMLA period ends *(mm-dd-yyyy)*

The employee is required to give a 30-calendar day advance notice or as soon as practicable. *(Check all that apply)*

9. I elect to substitute accrued leave for leave without pay as follows:

- ☐ Sick Leave From *(See attached DS-7100)*
- ☐ Annual Leave From *(See attached DS-7100)*

10. I will apply for the Shared Voluntary Leave Program (*Voluntary Leave Transfer and/or Voluntary Leave Bank*) under 3 FAM 3340.

- ☐ From _____ To _____

11. I understand that my family and medical leave will be granted provisionally until any required documentation is submitted.

Initials _____

12. I have invoked the FMLA in the past 12 months

- ☐ Yes If Yes, give date *(mm-dd-yyyy)* _____
- ☐ No

I understand that leave without pay is subject to regulations and procedures in 3 FAM 3510 including payment of federal employees health benefits. I certify that all statements that I have given above are true.

Employee Name	Signature	Date *(mm-dd-yyyy)*
Supervisor Name	Signature	Date *(mm-dd-yyyy)*
Bureau Executive Director Name	Signature	Date *(mm-dd-yyyy)*

Privacy Act Statement

AUTHORITY	Collection of this information is authorized by 5 U.S.C. §6381 – 6387, 5 C.F.R. §630.1201 – 1211, and 5 C.F.R. §890.502.
PURPOSE	The purpose of gathering this information is for management, human resources, and payroll officials to approve and record your use of leave under the Family and Medical Leave Act of 1993 pursuant to 5 C.F.R. §630.1201 – 1211.
ROUTINE USES	The information on this form may be shared with the Office of Personnel Management when the information is required for evaluation of leave administration. More information on the Routine Uses for the system can be found in the System of Records Notice STATE - 31, Human Resources Records.
DISCLOSURE	Disclosure of this information is voluntary. However, failure to provide the information requested on this form may result in delays in processing, or disapproval, of your request for leave under the Family and Medical Leave Act of 1993.