sabin METAL CORPORATION

1647 Wheatland Center Road • Scottsville, New York 14546

Refiners of Precious Metals
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(585) 538-2194
Fax# 585-538-2593

REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)

To be eligible for FMLA leave, the employee must have worked for the employer for at least 12 months; and have worked at least 1,250 hours during the 12 months before taking leave. Employees are expected to give 30-days advance notice of the need for FMLA leave. If it is not possible to give 30-days notice, an employee must notify the employer as soon as possible. Employee must provide sufficient information for the employer to determine if the leave may qualify for FMLA.

Employee Name: _____

Home Address: _____

Home Telephone: _____ Cel #: _____ Email: _____

Department: _____ Supervisor: _____

I am requesting FMLA as: (check one)

1. ☐ Continuous leave under the care of a licensed practitioner during a prolonged period of incapacity or convalescence due to illness, or
2. ☐ Intermittent leave or reduced work schedule for a chronic, severe medical condition requiring recurrent treatment by licensed petitioner.

   *The employee is **required** to furnish a written statement from a licensed practitioner to substantiate the need for intermittent leave and whether leave will be taken as needed or on a set schedule.*

Purpose of Leave (check one)

- ☐ The birth of a child or placement of a child for adoption or foster care
- ☐ To bond with a child (leave must be taken within 1 year of the child's birth or placement)
- ☐ To care for seriously ill family member (Employee's spouse, Child or Parent)

  Relationship: _____ Type of care required: _____
- ☐ For employee's own qualifying serious health condition
- ☐ To care for Covered Service Member
- ☐ For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child or parent.

FMLA Beginning Date: _____ **FMLA Ending Date:** _____

I certify that the information above is accurate. I understand that I may have to provide necessary medical documentation for any period of FMLA requested and that I will need to notify my department and / or Human Resources immediately if any of the information above should change.

Employee Signature _____ **Date:** _____

As the supervisor of the employee listed above, I am aware that the employee has applied for a Family Medical Leave Act leave. I will notify the Office of Human Resources immediately if I become aware of any changes to the information above.

Supervisor Signature: _____ **Date:** _____

Please return completed form and proper documentation to:
Human Resource Department