TAXATION & REVENUE NEW MEXICO

APPLICATION FOR FAMILY OR MEDICAL LEAVE (FMLA) [Non-fillable version (fill out by hand)]

Employee's Name: _____ _____
First Name Last Name

Employee ID No. (SHARE ID): _____ Division _____

Current Address _____
Street City State Zip

Anticipated Start Date of FMLA Leave: _____

Expected End Date of FMLA Leave: _____

Reason for Leave (Explain): _____

_____

_____

_____

_____

Note: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, parent, or *loco parentis* must be accompanied by a verifying medical certification from a physician.

I understand that, if my paperwork is incomplete or insufficient to process my application, HRB may contact me and have me contact my health care provider to request additional information for purposes of clarification and completing paperwork.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension of leave has been requested and approved in writing by TRD.

Employee Signature: _____ Date _____

Supervisor: _____ Date _____

Approved by:
FMLA Coordinator: _____ Date _____