Family Medical Leave and/or Dependent Care Leave Request Form
CONNECTICUT ONLY

Date:______________________

To:________________________________   ________________________________
(Supervisor's Name)   (Department)

From: ______________________________   ________________________________
(Employee's Name)   (Employee Badge/ID Number)

I hereby request:
Paid Dependent Care Leave of Absence for _____ days, from __________ through _____________.

Family Medical Leave of Absence for _____ days, from _____________ through _____________.

Reason for leave:	Check One: FMLA	Check One: Paid Dependent Care
Personal serious illness (Complete Certification of Health Care Provider **WH-380-E**)	☐	NA
Serious illness of your:		
Child (Complete Certification of Health Care Provider **WH-380**-F)	☐	☐
Spouse (Complete Certification of Health Care Provider **WH-380**-F)	☐	☐
Parent (Complete Certification of Health Care Provider **WH-380**-F)	☐	☐
Serious illness or injury of: Military Service member (Complete Certification of Health Care Provider **WH-385**)	☐	☐
Qualifying Exigencies for Military Leave (Complete Qualifying Exigencies for Military Leave form **WH-384**)	☐	☐
Birth of Child (Complete Certification of Health Care Provider **WH-380**-F)	☐	☐
Adopting or placement of a child for foster care	☐**	☐**

** Certification of Health Care Provider Form is not required for the Adoption or placement of a child for foster care. A copy of the adoption certificate or documentation of placement of a foster child will be required.

I understand that:

1. This request form should be submitted to my Supervisor at least 2 weeks before the beginning of the requested leave, if possible.

2. The FMLA Request Form and Certification of Health Care Provider (WH-380-E) will be required for **Hourly Bargaining Units** for time off due to **personal serious illness**. I will file a disability/sick pay claim with the UTC disability vendor after I have been out of work for *at least 6* consecutive work days.

   * **Hourly Bargaining Unit employees** fax disability claim form to **203-294-4298**

3. The FMLA Request Form and Physician Certification <u>will not</u> be required for **Salary and Hourly-Management Represented employees** for **personal serious illness** if approved by Liberty Mutual under the UTC Integrated Disability Program for a non-occupational illness/injury or maternity leave. FMLA leave runs concurrently with all approved Liberty absences. I will file a disability/sick pay claim with the UTC disability vendor after I have been out of work for *at least 6* consecutive work days.

   * **Salary and Hourly Management-Represented employees** call Access Direct at **1-800-243-8135**.

4. For **all employees** who request a leave due to a **personal serious illness (not associated with a disability claim), a birth of a child or the need to care for a seriously ill child, spouse, parent, qualifying exigencies or illness/injury of a service member**, I must complete the "Certification of Health Care Provider" form (see above for proper form) within 15 calendar days of receiving the Employer Response letter. (Please review Standard Work located on myHR under the Benefits "How Do I" section.) The Certification form should be faxed to the Windsor Locks Medical Department at 860-654-5816.

5. In order to be eligible for FMLA or Dependent Care Days, I must be employed by UTC for at least 12 months, and have worked a minimum of 1000 hours in the 12 months preceding my requested leave. I understand that I may take up to 16 weeks of FMLA in a 12 month period, if eligible.

6. If I am requesting to use Dependent Care Days, I must have enough sick time to cover the number of days I intend to take. (Please refer to the applicable sick day policy to determine the number of sick days for which you are eligible.) If available, I can use a maximum of 10 sick days as Dependent Care Days in a 2 year period.

7. The company may require periodic recertification during the leave, and may request a second medical opinion at the company's expense. If the first and second opinions differ, the company may require the opinion of a third health care provider (approved by both the company and me), whose opinion will be binding.
   NOTE: Recertification is mandatory for intermittent leave requests greater than 6 months.

8. Management approval is required to take *intermittent* FMLA or Dependent Care Days for the birth or adoption of a child.

9. Group medical, dental, employee basic life insurance and the Health Care Spending Account may continue at their current levels during unpaid Family Medical Leave. I am responsible for reimbursing the company for my employee contributions to the plan once I have returned to work. Payroll may make the necessary adjustments to my paycheck.

10. If I do not return to work following my Family Medical Leave, the company may request reimbursement for my group insurance premiums that were provided for my coverage during the period of family leave.

11. I must give my supervisor and Human Resources representative at least two weeks advance notification of the date I intend to return to work.

12. I may substitute accrued vacation pay for unpaid leave or use of Dependent Care Days.

13. Upon return to work, I will be entitled to restoration to the same or equivalent position.

I intend to return to work upon completion of my approved Family Medical Leave.

______________________________ ______________________________
(Employee's Signature) *(Date)*

______________________________ ______________________________
(Supervisor's Signature) *(Date)*

***SUPERVISORS**: SEND COMPLETED FMLA REQUEST FORMS TO HS DISABILITY COORDINATOR AT M/S 1-1-BC38; OR FAX TO 860-660-2826*

FOR MEDICAL USE ONLY: Medical Certification – Family and Medical Leave Act of 1993

____________Denied

____________Approved Date

____________More information required before judgment can be returned

____________Date Requested

____________Other