



**Colleton County Government  
 Human Resource Department  
 31 Klein Street  
 P. O. Box 157  
 Walterboro, South Carolina 29488  
 Phone: (843) 549-5221  
 Fax: (843) 549-7215**

**REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)**

Employees employed twelve (12) months or longer and who have worked 1,250 hours in the preceding twelve (12) months prior to the commencement of leave is eligible for Family Medical Leave.

Employee Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Department: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Address and Telephone #: \_\_\_\_\_

**TYPE OF LEAVE REQUESTED**

(Place an X next to the type of leave requested)

\_\_\_\_ Family Medical Leave (FMLA)    \_\_\_\_ Extension of Family Medical Leave

**REASON FOR LEAVE**

I am requesting family medical leave for the following reasons:  
 (Place an X next to the reason that applies to your request)

- \_\_\_\_ My own serious health condition
- \_\_\_\_ Serious health condition of my:    \_\_\_\_ Spouse    \_\_\_\_ Son/Daughter    \_\_\_\_ Parent
- \_\_\_\_ The birth of a child
- \_\_\_\_ Placement of a child with me for foster care
- \_\_\_\_ Adoption of a child by me
- \_\_\_\_ Because of a qualifying exigency arising out of the fact that my:
  - \_\_\_\_ Spouse    \_\_\_\_ Son//Daughter    \_\_\_\_ Parent is on active duty or called to active duty status in support of a contingency operation as a member of the National Guard or Reserves
- \_\_\_\_ Because I am the:
  - \_\_\_\_ Spouse    \_\_\_\_ Son/Daughter    \_\_\_\_ Parent    \_\_\_\_ Next of kin
 of a covered service member with a serious injury or illness

Leave or Extension Start date \_\_\_\_\_ Leave or Extension End date \_\_\_\_\_

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

\_\_\_\_\_  
 Date