



MEDICAL LEAVE OF ABSENCE/FMLA LEAVE REQUEST FORM

Name: _____ PIN: _____ Date: _____

Phone Number: _____ E-Mail: _____

Supervisor's Name: _____ Admin/Clerk: _____

Work Schedule: _____
Provide information on number of days worked per week/number of hours per day/off days if consistent

I am requesting FMLA leave for the following reason: (check one):

The birth of my son or daughter and to care for such child

Due Date/Birth date: _____ Name: _____

The placement of a son or daughter with me for adoption or foster care

Name of Child: _____ Date of Placement: _____

Serious health condition of:

Self

Spouse Name: _____

Child Name: _____ Date of Birth: _____

Parent Name: _____

Parent-in-law (Wisconsin) Name: _____

For the reason of:

Military-Exigency Name: _____

Military-Caregiver Name: _____

Requested leave time:

Continuously (Medical Leave of Absence) from _____ to _____

Intermittently beginning _____ (date if known)

If your intermittent leave is foreseeable you must provide CN with a schedule of your leave dates, please include that schedule when returning this form. A schedule would include dates you will be taking off for doctor appointments, physical therapy etc.

Signature: _____ Date: _____

Return completed form to Leave Administration via fax 708-332-4349, via email at FMLA@cn.ca or via mail to 17641 S. Ashland Ave., Homewood, IL 60430.

Please review the CN FMLA/MEDICAL LEAVE Policy and Procedures available on ePortal. For questions regarding the FMLA or Medical Leave or this form please contact Leave Administration at 1-800-253-1273, or via email at FMLA@cn.ca.