Family and Medical Leave Act of 1993

Supervisor Notification Form

Employee Name: ____

Department: ____

1. The date the leave or absence began: _____/_____/________

2. The employee listed above has worked at least 1,250 hours during the 12-month period immediately prior to the leave:

   Yes

   No

3. Did the employee request information on FMLA leave?

   Yes

   No

____

Supervisor's Signature

____

Date