Please Complete and Submit this Form to:

[Human.Resources@Ihserv.org](mailto:Human.Resources@Ihserv.org) or Fax to 413-831-6639

The purpose of this form is to notify my employer of my intent to apply for Paid Family & Medical Leave Benefits (PFML) with the Massachusetts Department of Family & Medical Leave. I understand that by submitting this form to my employer, I have not actually applied for PFML benefits; rather I have provided notice to my employer of my intent to apply for such benefits. I understand that in order to apply for and possibly receive PFML benefits, I must apply directly with the Department of Family and Medical Leave by going to their website [**www.mass.gov/DFML**](http://www.mass.gov/DFML).

* I acknowledge that I have received a copy of my company’s PFML policy and that I have completed my company’s PFML training.
* I understand that all employees returning from medical leave for their own serious health condition shall provide a fitness for duty certification to the company from a health care provider
* I acknowledge that leave taken under the Massachusetts Paid Family & Medical leave law shall run concurrently with leave taken under other applicable state and federal leave laws. This includes, but is not limited to, the Commonwealth’s Parental Leave Act, the federal Family and Medical Leave Act of 1993, as amended, when the leave is for a qualified reason under those acts.
* Any paid leave provided under a company policy and paid at the same or higher rate than paid leave available under this law counts against the allotment of leave benefits available under the Massachusetts PFML law.
* I understand that the Department of Family & Medical Leave, not my employer, determines if I am qualified to receive PFML benefits. I comprehend that the Department of Family & Medical Leave, not my employer, will notify me of whether my request for benefits was granted or denied.
* I understand that the Department of Family & Medical Leave has an initial 7 day waiting period which counts against the total available period of leave in a benefit year. During this 7 day waiting period, benefits are not paid by the Department; however, I may use my paid time off to the extent that such time is available by notifying my supervisor. The waiting period applies for each application of benefits except medical leave during pregnancy or recovery from childbirth if this is supported by documentation from a health care provider.

**Employee Information**

Name (First, Last, Middle):

Home Address:

Job Title/Department:

Telephone Number:

Email Address:

Date of Completing This Form:

**Absence Information:**

* This is a New Request
* This is an Update to an Existing Request

**Requested Start Date: Requested End Date:**

**Type of Leave:**

* Consecutive Leave of Absence
* Agreed to Intermittent or reduced schedule leave Absence

An employee who is approved for and takes leave on an intermittent or reduced leave schedule and who fails to work during the times or on the schedule agreed to with the Company may be subject to discipline. Intermittent or reduced schedule leave cannot be used to bond with a child during the first 12 months after the child's birth, adoption, or foster care placement.

**Reason(s) for Leave:**

**Please indicate the applicable reason(s) for your leave below. If you require additional information about leave types and their qualifying criteria, please contact Lori Quarterson at** [**lori.quarterson@ihserv.org**](mailto:lori.quarterson@ihserv.org)**.**

* Employees Own Serious Health Condition if they have a serious health condition that incapacitates them from work (intermittent or reduced schedule leave may only be taken if medically necessary).
* Birth, adoption, or foster care placement of a child.
* Because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces.
* To care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member’s military service.
* To care for a covered family members serious health condition.

Family members include: your spouse, domestic partner, child, parent, grandchild, grandparent or sibling; the parent of your spouse or domestic partner; and guardians who legally acted as a parent when you were a minor.

* **Job Protection:** Generally, if you take Massachusetts PFML and return to your job at the close of the period of approved family or medical leave, you will be restored to your previous position or to an equivalent position, with the same status, pay, employment benefits, length-of-service credit and seniority as of the date of leave.
* **Continuation of Health Insurance:** The Company will continue to provide for and contribute to your employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if you had continued working continuously for the duration of such leave. The employee portion of the employee's employment-related health insurance benefits shall be remitted by the employee in accordance with the Company’s policies.
* **No Retaliation:** The Company will not discriminate or retaliate against you for exercising any right to which you are entitled under the paid family and medical leave law. An employee or former employee who is discriminated or retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court.

Employee Signature:

**THIS SECTION FOR HUMAN RESOURCES COMPLETION ONLY**

Company representative verifying that the above listed employee provided notice to our company of their intent to apply for PFML benefits with the Department of Family & Medical Leave:

Name of Company Representative (PRINT):

Company Representative Signature:

Name of Company:

Date: