

**Certification of Qualifying Exigency  
For Military Family Leave  
(Family and Medical Leave Act)**

**U.S. Department of Labor**  
Employment Standards Administration  
Wage and Hour Division

**Adopted by  
Iowa County  
January 2009**  
OMB Control Number: 1215-0181

**SECTION 1: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

**SECTION II: For completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to a qualifying exigency. Be as specific as you can; terms such as "unknown", or "indeterminate" may not be sufficient to determine your FMLA coverage. Your response is required to obtain a benefit. 20 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: \_\_\_\_\_  
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

\_\_\_\_\_  
First Middle Last

Relationship of covered military member to you: \_\_\_\_\_

Period of covered military member's active duty: \_\_\_\_\_

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one on of the following:

- \_\_\_\_\_ A copy of the covered military member's active duty orders is attached.
- \_\_\_\_\_ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- \_\_\_\_\_ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

**PART A: QUALIFYING REASON FOR LEAVE**

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for information briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services or the handling of legal or financial affairs.

Available written documentation supporting this request for leave is attached. \_\_\_ Yes \_\_\_ No \_\_\_ None Available

**PART B: AMOUNT OF LEAVE NEEDED**

1. Approximate date exigency commenced: \_\_\_\_\_

Probable duration of exigency: \_\_\_\_\_

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

\_\_\_ Yes \_\_\_ No If so, estimate the beginning and ending dates for the period of absence: \_\_\_\_\_

3. Will you need to be absent from work periodically to address this qualifying exigency? \_\_\_ Yes \_\_\_ No

Estimate schedule of leave, including the dates of any scheduled meetings or appointments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Estimate the frequency and duration of each appointment, meeting or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: \_\_\_ times per \_\_\_ week(s) \_\_\_ month(s) Duration: \_\_\_ hours \_\_\_ day(s) per event.

**PART C:**

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meeting with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any even sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Describe the nature of the meeting: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART D**

I certify that the information I provided above is true and correct.

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

\_\_\_\_\_  
Date

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR: RETURN TO THE PATIENT.**