STATE OF IDAHO FMLA DECLINATION FORM

Employee Name (Printed):_____

Agency Code:_____ **Job Title:**_____

Personal Email:_____ **Personal Phone Number:**_____

Please initial each item and sign below to indicate you have read them:

_____ I have received and reviewed my Family and Medical Leave Act Eligibility and Rights and Responsibilities notices and by my signature below I am affirmatively choosing to decline Family Medical Leave job protection for my requested absence.

_____ I understand that declining job protected leave under the Family and Medical Leave Act may result in my absence factoring into the evaluation of my job performance.

_____ I understand that this declination does not preclude me from requesting and/or accessing job protected leave under the Family Medical Leave Act at any time in the future.

_____ I understand that the agency requires me to use and exhaust available paid leave (Compensatory Time, On Call Time, if applicable, Vacation, and Sick Leave) to cover any period of absence before taking leave without pay.

_____ I understand that absences not covered by the Family Medical Leave act may be subject to the Idaho Division of Human Resources rules and statutes concerning reliable and predictable job performance, including causes for disciplinary action.

_____ I understand that I must follow my division/department's call-in procedures for any unscheduled absences.

_____ _____

Employee Signature **Date**