Family Medical Leave Act (FMLA)
Certification of Adoption or Foster Care Placement

Failure **to fully complete this form could result in an initial denial of an FMLA Leave or a delay in approval of an FMLA Leave for the employee.** Where the need for leave is foreseeable, such as for an expected adoption or foster care placement, an employee provides at least 30 days advance notice of the need for leave to the supervisor whenever possible.

The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found https://www.dol.gov/agencies/whd/fmla. This information includes the anticipated timing and duration of the leave.

Section I: To be completed by Employee

INSTRUCTIONS: Ensure that Sections I and II are completed before giving this form to the professional/agency. By signing this form, you represent that the information you provided is true and correct. Unless advised otherwise in writing, you have 15 calendar days to return this form to your supervisor/responsible administrator.

Qualifying Event for which leave is being requested: ( ) Adoption ( ) Foster Care Placement

Employee name: _____ Employee's job title: _____

Employer name: _____ Date: _____ *(mm/dd/yyyy)*

The medical certification must be returned by _____*(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

Section II: Amount of Leave Needed

Your answer should be your **best estimate** based upon your knowledge and experience to determine FMLA coverage.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of requested leave.

Anticipated or actual placement date: _____

If leave is necessary prior to the date of adoption/foster care placement, such as for court appearances, counseling, etc., indicate the date(s) and reason(s) below:

Date	Reason – provide brief description

You have **30 calendar days** from the date of the event to request eligible benefit changes by submitting a ***Benefits Enrollment/Change Form*** located in the Employee Health Benefits section of the Human Resources website.

Section III: For Completion by the Professional Agency in Charge of Placement

INSTRUCTIONS: Please provide the following information and be sure to sign the form representing that the information provided is accurate.

Professional/Agency Name:_____

Address: _____ City, State, Zip _____

Telephone: _____ Fax: _____

Anticipated or actual placement date: _____

Professional/Agency Contact Name: _____ Phone: _____

Professional/Agency Signature: _____ Date Signed:_____ *(mm/dd/yyyy)*

Type(s) of documentation attached/to be provided at a later date (if applicable):

- ◯ Foster care/adoption placement letter.
- ◯ Adoption court documents.
- ◯ Birth certificate/certification of birth.
- ◯ Adoption/foster care agency documents for pre-placement activities.
- ◯ Other [explain]:_____

I,_____, attest that I am in the process of _____ a child. I am requesting leave under the Family and Medical Leave Act for time needed to fulfill prerequisites prior to the placement and/or for bonding leave after the placement of the child in my home. As per the City of Brockton's Family Medical Leave Policy, I will provide substantiation above and as warranted throughout the placement process.

Employee Signature: _____ Date: _____*(mm/dd/yyyy)*