PLUMBERS, PIPEFITTERS & MES LOCAL UNION NO. 392 HEALTH & WELFARE FUND
1228 Central Parkway, Room 100 · Cincinnati, OH 45202-7500
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FAMILY MEDICAL LEAVE AND BEREAVEMENT LEAVE FORM

Section I: Employee Information

Name: _____ Leave Commencement Date: _____

Member SS#:_____ Days/Weeks of Anticipated Leave: _____

Phone #: _____

It is your responsibility to contact the Fund Office if returning to work before the time you stated. If you return to work, and you are being paid Benefits, you will be required to reimburse the SUB Fund for the time you were paid.

Reason Leave Requested (check one):

1. ☐ A serious health condition affecting your ☐ spouse, ☐ child, or ☐ parent, for which you are needed to provide care.
2. ☐ The birth of a child or the placement of a child with you for adoption or foster care.
3. ☐ The death of an immediate family member:

   ☐ spouse, ☐ child/stepchild, ☐ parent/stepparent, ☐ parent-in-law, ☐ sibling, ☐ grandparent
4. ☐ A qualifying exigency arising from the employee's: ☐ spouse, ☐ child, or ☐ parent
5. ☐ To care for a covered military service member: ☐ spouse, ☐ child, ☐ parent, or ☐ next of kin

Employee Signature: _____ Date: _____

Section II: Employer Information

EMPLOYER APPROVAL: The above employee is approved for a Family Medical Leave or Bereavement Leave Benefit based on the date and number of weeks noted above.

Employer Name: _____ Phone#:_____

Name of Employer Representative: _____

Signature: _____ Date: _____