Certification of Adoption or Foster Care Placement

Family and Medical Leave Act (FMLA)

SECTION I: Completion by the SUPERVISOR/RESPONSIBLE ADMINISTRATOR or EMPLOYEE

INSTRUCTIONS: Ensure Sections I and II are completed before giving this form to the placement professional or agency.

Employer name including department/unit:	
Supervisor/Responsible Administrator name:	
Employee's job title:	Employee's regular work schedule:

SECTION II: Completion by the EMPLOYEE

INSTRUCTIONS: Ensure 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.

Employee Name:	Qualifying Event: ☐ Adoption ☐ Foster care placement
Date leave to begin:	Date leave to end:
Signature of employee:	Date signed:

SECTION II: Completion by the PROFESSIONAL/AGENCY

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

Professional/Agency name, including contact and business address:	
Actual or anticipated date of adoption/placement:	
Telephone (with area code):	Fax (with area code):
Signature of professional/agency official:	Date signed: