

FMLA Affidavit of Family Relationship

In order to approve your request for your leave to be covered under FMLA, [company name] is requesting information and documentation of your relationship to the individual for whom you will be caring. Please complete this form and attach relevant documentation as necessary. Return this form to [name] by [date].

Employee name: _____

Reason for FMLA leave: _____

Family member's name: _____

Relationship to employee: _____

Family members covered under the federal FMLA include:

- *Parent (biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the employee when the employee was a son or daughter).*
- *Spouse.*
- *Child (biological, adoptive, step or foster children, legal wards, or a child of a person standing in loco parentis of the employee). Note: Child must be either under age 18, or age 18 or older and "incapable of self-care because of a mental or physical disability" at the time that FMLA leave is to commence.*
- *For purposes of military caregiver leave under FMLA, next of kin of a covered service member means the nearest blood relative other than the covered service member's spouse, parent, son or daughter in the following order of priority: Blood relatives who have been granted legal custody of the covered service member by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins unless the covered service member has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under the FMLA.*

**In-laws, grandparents, siblings and other extended family members are NOT covered by FMLA or company policy unless an in loco parentis relationship exists.*

To verify that our relationship entitles me to FMLA leave to care for this individual, I have attached a copy of the following:

____ Birth certificate

____ Marriage certificate

____ Court document: _____

OR

_____ I certify that the family member for whom I need to provide care for a serious health condition under the FMLA is a covered family member as defined above.

Employee signature: _____ Date: _____