**FMLA INTERFERENCE OR RETALIATION QUESTIONNAIRE**

Thank you for contacting Albeit Weiker, LLP. To allow us to evaluate your claim accurately, please complete as much information as you can below. If unsure, leave it blank.

**Please email the completed form to mark@awlawohio.com or fax it to (614) 417-5081. Once returned, we will contact you to schedule your free consultation.**

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| **Full Name:** |  | | | | | | | | |
| **Address:** |  | | | | | | | | |
| **DOB:** |  | | | **Telephone:** | | | |  | |
| **Email:** |  | | | | | | |  | |
| **Were you an independent contractor or employee?** | | | | |  | | | | |
| **Are you interested in continuing in the same job? (Y/N)** | | | | | | | |  | |
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| **FMLA Related Claims** | | | | | | | | | |
| **Have you requested FMLA? (Y/N)** | | | | | | | | |  |
| **What was the reason for leave? (highlight one)**   * Parental Leave after the Birth of a Child * Pregnancy Leave, Adoption or Foster Care * Medical Leave to Care for a Family Member with a \*Serious Health Condition   (must be spouse, child or parent)   * Medical Leave for Your Own \*Serious Health Condition   **Intake note**: A "serious health condition" means any illness, injury, impairment, or physical or mental condition that involves *either inpatient care or continuing treatment by a health care provider*. | | | | | | | | |  |
| **What was the date that you communicated this request to your employer?** | | | | | | | | |  |
| **If you marked that you asserted a protected right, how was this communicated to your employer?** | | | | | | | | |  |
| **Was the leave approved? (Y/N)** | | | | | | | | |  |
| **If the FMLA leave was not approved, what was the reason given for the denial?** | | | | | | | | |  |
| **Did you work at least 1250 hours over the preceding year (Y/N)? (Note: teachers are presumed to have met this requirement)** | | | | | | |  | | |
| **Does the employer have more than 50 employees in a 75-mile radius? (Y/N)** | | | | | | |  | | |
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| **TYPE OF LEAVE** | | | | | | | | | |
| **Was the leave continuous (2+ days away from work), or intermittent (at random times or as needed)?** | | | | | | | | |  |
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| **ADVERSE ACTION: Were you subjected to an adverse employment action (see list below) after you asserted the protected right? (Y/N)** | | | | | | | | |  |
| **Highlight or underline all that apply:**   * Suspension (of at least 5+ days)? * Termination? * Forced Resignation? | | | | | | | | | |
| **Date of adverse action?** | |  |  | | | | | | |
| **Reason stated by employer for the adverse action (e.g. reason for termination)?** | | |  | | | | | | |
| **Do you believe that requesting FMLA was the real reason for termination/suspension? (Y/N)** | | |  | | |  | | | |
| **If no, what do you believe was the real reason for termination/suspension?** | | |  | | | | | | |
| **Termination/suspension/resignation date?** | | |  | | | | | | |
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**Please provide any additional information you believe is important for us to know prior to your consultation:**

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