Disability / Family Medical Leave Request Form

Employee Instructions

This form must be completed by employees to request a leave of absence due to a disability or Family Medical Leave. Please complete the form and forward it to your local Human Resources department.
After submitting the form, you must report your disability to Aetna either by phone or via Aetna's web portal.

Toll Free Number
866-269-6241
Hours of Operation: 8am to 8pm Eastern Time

Aetna's Workability Customer Intake Portal (WCP)
URL: https://www.wkabsystem.com
Identifier: MCCLATCHY
Availability: 24 hours a day

Employee Information

Employee Name: _____ Employee ID: _____

Personal Phone: _____ Home Address: _____

Personal Email Address: _____ City: _____ State: ____ Zip: _____

Department: _____ Supervisor's Name: _____

Regular Work Week Schedule: _____ Regular Work Hours: _____

Absence Information

Leave Start Date: _____

If eligible, would you like to receive supplemental pay? ☐ Yes ☐ No

Type of Leave Applying for (Check all applicable boxes):

☐ Non Work Related Medical Leave

☐ Pregnancy/Maternity/Paid Family Leave (PFL)

☐ Paternity Leave/Paid Family Leave (PFL)

☐ Work Related Medical Leave Family

☐ Medical Leave (FMLA)

☐ Military Leave (USERRA/FMLA)

Employee Signature: _____ Date: _____

Employee Checklist

	Yes	No
1. Have you notified your supervisor about the leave?	○	○
2. Is your illness or injury work-related? If yes, please contact HR to complete the workers' compensation paperwork.	○	○