REQUEST FOR FAMILY MEDICAL LEAVE

Employee Name: _____ Date of request: _____

School/Building: _____ Hire date: _____

Position/Title: _____

I request a Family Medical Leave for the following reason (check one):

☐ A. The birth of a child and in order to care for such child or the placement of a child for adoption or foster care

☐ B. In order to care for an immediate family member if such family member has a serious health condition.
Circle which family member: CHILD - SPOUSE - PARENT
(Must submit "Physician or Practitioner Certification" within 15 days)

☐ C. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.
(Must submit "Physician or Practitioner Certification" within 15 days)

Methods of Leave Requested

☐ A. Consecutive Leave

☐ B. Intermittent or Reduced Leave Schedules
(specify schedule below):

_____

_____

_____

Date leave is to begin: _____ Expected duration of leave: _____

12 weeks of FMLA ends: _____

If the duration of my FLMA (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my FMLA should exceed 12 weeks, I will be returned to my same or similar position, only if available, in accordance with applicable laws.

_____
Employee Signature

_____

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Date