

Licensed Employee Family and Medical Leave Request Form

Date Sent: _____

To: _____

1. If applying for the Family Medical Leave, please check the appropriate reason(s) below.

- a. _____ For the birth of my child.
- b. _____ For the placement of a child for adoption or foster care.
- c. _____ To care for my child who has a serious health condition.
- d. _____ To care for my parent who has a serious health condition.
- e. _____ To care for my spouse who has a serious health condition.
- f. _____ Because I am seriously ill and unable to perform the essential functions of my position.

2. I request that my Family and Medical Leave begin on _____.

3. Please check type of leave requested:

- a. _____ Continuous
- b. _____ Intermittent or Reduced Work Schedule

Details of the leave needed:

4. I anticipate returning to work at my regular schedule on _____.

5. I ___ will ___ will not be required to have a physician complete the Family and Medical Leave Certification form.

6. I ___ will ___ will not be required to provide the school district a physician's release prior to returning to work.

~ see reverse side ~

I realize I may be moved to an alternative position during the period of the Family and Medical Intermittent or Reduced Work Schedule Leave. I also realize that with foreseeable Intermittent or Reduced Work Schedule Leave, subject to requirements of my health care provider, I may be required to schedule the leave to minimize school district operations.

While on Family and Medical Leave, I agree to pay my regular contributions to employer sponsored benefit plans. My contributions shall be deducted from monies owed me during the leave period. If no monies are owed me, I shall reimburse the school district by personal check (cash) for my contributions. I understand that I may be dropped from the employer-sponsored benefit plans for failure to pay my contribution.

I agree to reimburse the school district for any payment of my contributions with deductions from future monies owed to me or the school district may seek reimbursement of payments of my contributions in court.

I understand that I am required to notify the school district two days prior to returning to work.

I acknowledge that the above information is true to the best of my knowledge.

Signed _____ Date _____