EMPLOYEE FAMILY AND MEDICAL LEAVE REQUEST FORM

Date:_____

I, _____, request family and medical leave (according to The Family and Medical Leave Act of 1993) for the following reason: (check all that apply)

_____ Birth of my child;

_____ Placement of a child for adoption or foster care;

_____ Care for my family member (child, parent, spouse) who has a serious health condition;

_____ I am seriously ill and unable to perform the essential functions of my position;

_____ Extended leave for illness/surgery

I request that my family and medical leave begin on or around _____ and I request leave as follows:

_____ Continuous

_____ Intermittent (please describe the intermittent leave below)

_____

_____

_____ Reduced work schedule (please describe the reduced work schedule below)

_____

_____

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

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

Signed: _____

Date: _____

*Please return to the Business Office.

Office Use:

Date received:_____ Approved / Denied

Office Signature:_____

EMPLOYEE FAMILY AND MEDICAL LEAVE

While on family and medical leave, I agree to pay my regular contributions to employer-sponsored benefits. My contributions will be deducted from wages owed to me during the leave period. If no wages are paid during any part of my leave, I agree to reimburse the school district for my contributions. I understand that I may be dropped from the employer-sponsored benefit plans for failure to pay my contributions.

Following are the employer-sponsored benefits in which I participate:

_____ Medical Insurance

_____ Dental Insurance

_____ Life Insurance

I plan to cover any part of my leave by using the following: (please indicate # of days you will be using in each category)

_____ Personal days:

_____ Sick leave:

_____ Family Illness (max. of 10, comes from sick leave balance):

_____ Vacation

Here is how I would like the paid leave to be applied:

_____

_____

_____

Signed: _____

Date: _____