To request leave on the basis of the Family and Medical Leave of Act (FMLA), please complete the following request form and submit to Human Resources at least 30 days prior to leave (unless leave is unforeseen, in which case submit the form as soon as practical). **Please print clearly.**

Employee Name: _____

Alternative E-mail Address: _____

Requested Leave Start Date: _____ Estimated End Date: _____

**The reason for this FMLA leave request is (select the most appropriate box):**

❑ Birth of a son or daughter and to care for the newborn child.

❑ Placement with the employee of a son or daughter for adoption or foster care.

❑ To care for the employee's spouse, son, daughter or parent with a serious health condition.

❑ A serious health condition that makes the employee unable to perform the functions of the employee's job.

❑ A qualifying exigency arising out of the fact that the employee's spouse, son, daughter or parent is a military member on covered active duty (or has been notified of an impending call or order to covered active duty status).

❑ To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the covered service member.

**Time off work is expected to be (select the most appropriate box):**

❑ For a continuous block of time (several continuous days, weeks or months off work).

❑ For a reduced work schedule (change in work schedule needed—fewer hours per day or fewer hours per week).

❑ On an intermittent basis (periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups of a medical condition and/or for ongoing medical treatment/appointments).

**Upon any extended leave from the District, all district-owned devices including but not limited to laptops must remain in the classroom. All email communications from the Administration Office will be sent to the alternative email address listed on this form.**

While on family and medical leave, I agree to pay my regular contributions to employer sponsored benefit plans. My contributions shall be deducted from moneys owed me during the leave period. If no monies are owed to me, I shall reimburse the 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.

Additional information about employee FMLA rights and responsibilities will be provided to you in writing within five business days after receipt of this notice (unless already provided).

Determination of eligibility for leave under the FMLA, and/or additional documentation or clarification of documentation, may be required prior to making a final FMLA determination to approve or deny an FMLA leave request. Please contact Human Resources with any questions.

I acknowledge my obligation to provide medical certification of my serious health condition or that of a family member or that of a covered service member in order to be eligible for family and medical leave within fifteen (15) calendar days of a request for certification.

Employee Signature: _____ Date: _____

Return to Human Resources Department

*For HR use ONLY:*

Date received: _____ FMLA Eligibility Notice sent: _____ Ent'd in SUI_____