

Personnel

Series 400

Policy Title: Employee Family and Medical Leave - Request Form

Code No. 409.3-E2

FAMILY AND MEDICAL LEAVE REQUEST FORM

Date:

I, _____, request family and medical leave for the following reason: (check all that apply)

- for the birth of my child;
- for the placement of a child for adoption or foster care;
- to care for my child who has a serious health condition;
- to care for my parent who has a serious health condition;
- to care for my spouse who has a serious health condition;
- because I am seriously ill and unable to perform the essential functions of my position; and
- Military Family Leave Entitlement.

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

I acknowledge receipt of information regarding my obligations under the family and medical leave policy of the school district.

I request that my family and medical leave begin on _____ and I request leave as follows: (check one)

Continuous

I anticipate that I will be able to return to work on _____.

OR

Intermittent leave for an average of _____ hours per week.

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

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 the 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 understand that I must substitute unpaid leave with appropriate paid leave. The leave will be deducted in the following order: personal sick leave or family illness leave (whichever is applicable), personal leave, and then vacation leave. The remaining FMLA leave will be unpaid.

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

Signed _____ Date _____

Amended: April 24, 1995
October 19, 2009
August 19, 2020

Reviewed: September 9, 2013
October 16, 2017