REQUEST FOR FAMILY / MEDICAL LEAVE

Employee Name:_____ Date of Request: _____

Department:_____ Position Title:_____

Hire Date:_____

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

A)_____ The birth of a child and/or in order to care for such child.

B)_____ The placement of a child for adoption or foster care.

C)_____ In order to care for an immediate family member because such family member has a serious health condition.
Circle One: **CHILD SPOUSE PARENT**
(Must submit "Physician Certification" within 15 days).

D)_____ My own serious health condition.

METHOD OF LEAVE REQUESTED

A)_____ Consecutive Leave

B)_____ Intermittent or Reduced Leave Schedule (Specify Schedule Below)

_____

_____

_____

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

If the duration of my family / medical leave (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 family / medical leave should exceed 12 weeks, I will be returned to my same or equivalent position, only if available. If my same or equivalent position is not available, I understand that I may be terminated. I understand that if I do not return to employment, I will be responsible for repayment of any health insurance premiums paid by the District while on Family / Medical Leave.

Date _____ Employee Signature: _____

Print Name:_____