



MANKATO AREA PUBLIC SCHOOLS  
Independent School District No. 77  
Office of Human Resources

**APPLICATION FOR LEAVE OF ABSENCE  
UNDER THE  
FAMILY MEDICAL LEAVE ACT (FMLA)**

Employee's Name: \_\_\_\_\_ Employee #: \_\_\_\_\_ Date: \_\_\_\_\_

Job Title: \_\_\_\_\_ Location: \_\_\_\_\_

Leave Start Date: \_\_\_\_\_ Return to Work Date: \_\_\_\_\_

**\*\*"Eligible employee" means an employee who has been employed by the school district for a total of at least 12 months and who has been employed for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave.**

Have you taken a Family/Medical Leave within the last 12 months?  Yes  No

This Family/Medical Leave is for:

- Birth/Adoption/Foster care of a child
- Serious health condition of employee
- Serious health condition of family member:  Child  Spouse  Parent
- Active duty or call to covered active duty with Armed Forces:  Spouse  Son/Daughter  Parent
- Next of kin of a covered servicemember with a serious injury/illness:  
 Spouse  Son/Daughter  Parent

Will you be using any accrued sick leave during this leave?  No  Yes, # of days: \_\_\_\_\_

Will you be using any accrued vacation time during this leave?  No  Yes, # of days: \_\_\_\_\_

Will you be using any accrued personal leave during this leave?  No  Yes, # of days: \_\_\_\_\_

***Please note: Sick leave will be deducted first, then vacation and/or personal leave, then unpaid days.***

Will this leave be taken in an intermittent/reduced schedule?  No  Yes, please explain:  
\_\_\_\_\_

I understand that my insurance benefits will be continued during my leave for up to 60 work days provided I continue to pay the employee portion of the premium. If the insurance premium is not deducted from my paycheck, it is due by the 1<sup>st</sup> of each month. If payment is not made within 30 days, I understand that my benefits may be discontinued.

I understand that the school district will return me to the same or an equivalent position upon my return from leave. However, I will have no greater right to reinstatement or to other benefits and conditions of employment than if I had been continuously employed during the leave. I affirm that I have read Policy 410, Family and Medical Leave Policy.

Leave for the serious health condition of the employee or the covered family member requires medical certification, completed by the medically disabled individual's physician within 15 days of the application or as soon as practicable under the circumstances.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Submit Application to the Human Resources Office**