NOOKSACK VALLEY SCHOOL DISTRICT
EMPLOYEE FMLA (Family and Medical Leave Act) REQUEST FORM

A. General Information ***(Only Sections A, B (a&b) & E to be completed by employee and then have your supervisor sign page 3)***

Employee Name: ___________________________ Date of Request: __________________

Job Site/Position: ____

Date of Hire/Rehire: _________ Date/Request Leave to Begin: ________ End: _________

Anticipated Duration of Leave: ____

Please Note: ***This form should only be completed when leave is expected to exceed five days***

B. Eligibility Factors

a. Reason for Leave Request:

___ Birth of Child ___ Placement of child for adoption or foster care

___ Serious health condition of : ❑child up to 18 years old ❑parent ❑spouse

___ Serious health condition of employee

b. Type of Leave:
___ Medical Leave ___ Personal Leave ___ Vacation Leave

___ Other Leave (unpaid, L&I, etc) (specify):______________________________

___ Family & Medical Leave (FMLA) (May use paid and/or unpaid leave): **FOR FMLA Leave, you must meet the following eligibility:**

c. Has the employee completed at least 12 months of employment? ___ Yes ___ No

d. Has the employee worked at least 1,250 hours during the 12 month computation period (School year start date)? ___ Yes ___ No

e. Has the employee taken any other family or medical leave under the FMLA and/or state law for this or any other reason during the 12-month computation period?
___ Yes ___ No

If "yes," please state the dates each such absence occurred and the number of work days or hours missed on each occasion:

Dates of Absence	Reason for Leave	Time Missed
______________	____	________________

f. If the requested leave is due to the birth of a child or placement of a child for adoption or foster care, will the leave end within one year of the birth/placement of the child?
___ Yes ___ No

C. Notice Provisions

a. If this event was foreseeable, did the employee provide at least 30 calendar days advance notice in writing? ___ Yes ___ No

b. If this event was unforeseeable 30 days in advance, did the employee provide as much advance notice as practicable after learning of the need for the leave? ___ Yes ___ No

c. Where a leave is requested due to a serious health condition of the employee or the employee's child, spouse, or parent, is the request supported by a sufficient medical certification by a health care provider? ___ Yes ___ No

d. The family leave shall be without pay, unless the employee is eligible to use all or part of his/her entitled accumulation of paid leave as part of the twelve-week family leave.

e. A husband and wife employed by the district may take family leave to care for a new child together, but the aggregate total is limited to twelve weeks.

D. Insurance obligations

a. Has the employee been provided written notice of the terms and conditions under which the employee must pay the employee's share of health insurance coverage costs?
___ Yes ___ No

b. Has the employee been advised that the employee will be responsible for the costs of maintaining other insurance coverage (such as life and disability insurance coverage, where applicable) during the leave and that the employer is authorized by federal law to recover such costs from the employee? ___ Yes ___ No

E. Employee Request

I request a family/medical leave of absence to begin on the date specified in Section A. I understand my continued obligation to pay my share of all health insurance premiums in a timely manner (by the fifth of each month for the following month) during the leave, unless I decline to continue my coverage during my leave by submitting a written waiver.

I acknowledge that I will be guaranteed reinstatement from an approved family/medical leave to the same or an equivalent position subject to the terms, conditions, limitations, and exceptions provided by law. I also understand that any unpaid leave will not count toward retirement service credit.

My signature attests to the fact that I have read the entire attachment regarding my rights and obligations under the Family Medical Leave Act, understand all information on this form, and agree to observe all requirements.

Employee Signature: ___________________________________ Date: ________________

F. Employer Action

a. The requested leave is approved to begin _____________ and end ________________.

b. You ❑ will ❑ will not be required to present a fitness-for-duty certificate before being restored to employment. If such certificate is required but not received, your return to work may be delayed until such certification is provided.

c. You ❑ are ❑ are not a “key employee” as described in the regulations. If you are a key employee, restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic harm to the district.

d. You have ________/________ (days/hours) of accrued leave. When accrued leave is exhausted, you will have _______/_______ (days/hours) of unpaid leave.

e. You ❑ are ❑ are not eligible to apply for shared leave.

f. Physician Documentation Attached: ____________ Total Days of Leave: ____________

g. Board approval (if required) date: ______________________

Additional Comments:

____

____

____

NOTE: ***ALL absences must be reported on a monthly time sheet, signed by employee and principal/supervisor and submitted to payroll.***

____ _________________________

Superintendent’s Signature Date

____ _________________________

Signature of Immediate Supervisor Date