

THE EDISON TOWNSHIP BOARD OF EDUCATION
Family Leave and Medical Leave Form

APPLICATION FOR LEAVE OF ABSENCE

Print Name of Employee: _____

Employee's Current Address: _____

Telephone Number: _____ School: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (Please check one of the following):

- the birth of your child;
- the placement of a child with you for adoption or foster care;
- a serious health condition that prevents you from performing the essential functions of your job;
- a serious health condition affecting your ___ spouse/civil union partner; ___ dependent child; ___ parent, for which you are needed to provide care;
- a qualifying exigency arising out of the fact that your ___ spouse; ___ son or daughter; ___ parent is a covered military member on active duty or has been notified of an impending call or order to active duty status in the National Guard or Reserves in support of a contingency operation; or
- you are the ___ spouse; ___ son or daughter; ___ parent; ___ next of kin of a covered servicemember with a serious injury or illness, who requires your care.

NOTE: An Application for Leave of Absence due to the serious health condition of an employee or an employee's spouse/civil union partner, dependent child, or parent must be accompanied by a completed and signed Certification of Health Care Provider.

An Application for Leave of Absence due to a qualifying exigency must be accompanied by a completed and signed Certification of Qualifying Exigency For Military Family Leave.

An Application for Leave of Absence because you are the spouse, son, daughter, parent, or next of kin of a covered servicemember with a serious injury or illness, who requires your care must be accompanied by a completed and signed Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave.

By submitting this Application for Leave of Absence, I hereby authorize The Edison Township Board of Education to contact my health care provider to verify the reason for my requested leave, or for any other information concerning my Application for Leave of Absence.

I understand that failure to return to work at the end of my leave period will be treated as a resignation from my employment.

Employee's Signature

Date

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Please complete section below, if applicable:

**EMPLOYEE'S DESCRIPTION OF NEED
TO CARE FOR A FAMILY MEMBER**

Describe the care you will provide and give an approximate time period during which care will be provided:

Employee's Signature

Date