Application for Family or Medical Leave

Name: ____ Teams ID: ____________________

Campus: _________________________________ Assignment: ________________________________

Current Address: ____

Start Date of Anticipated Leave: _________________ Expected Date of Return to Work: __________________

Reason for Leave (Explain): ____

____

Work Related? Yes ____ No ____

If leave is for illness or death of immediate family member, state relationship: ___________________________

Note: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification physician within 15 days of application for leave.

I authorize a representative of Carrollton-Farmers Branch ISD to contact my health-care provider to verify the authenticity of the medical certification for my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as absent without leave, and may result in further disciplinary action up to and including termination of employment, unless additional leave, pursuant to Board Policies DEC(Legal) and DEC(Local) has been agreed upon and approved in writing.

Type of leave Requested:

FMLA: __________ Sick Leave Bank: __________ Extended Sick Leave: __________ Work Comp __________

Signature: ____ Date: _________________________

I prefer communication be submitted to me via ☐U.S. Mail or ☐district e-mail.

Received by:

Supervisor/Principal: _____________________________________ Date: _________________________

Payroll Department: ______________________________________ Date: _________________________

Approved by Sick Leave Bank Committee: Yes _____ No _____

Payroll Director: ____ Date: _________________________