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 12 work weeks 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 1st 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