Pequannock Township School District

FAMILY AND MEDICAL LEAVE ACT (hereinafter "FMLA") & NEW JERSEY FAMILY LEAVE ACT (hereinafter "N.J. FLA") REQUEST FORM

TO: Superintendent of Schools

FROM: _____ **SCHOOL/TITLE:** _____
(Name) (School and Job Title)

RE: Request for FMLA and/or N.J. FLA

Date of Request: _____

Please select the leave(s) which apply to your request:

A. I require a leave of absence under *FMLA from _____ to _____
(Start Date) (End Date)

Please state the reason for your leave request in the space provided:

_____
_____
_____
_____
_____

I have attached a completed Medical Certification form from a health care provider certifying my need for a leave of absence under FMLA. Failure to submit a Medical Certification may result in denial of the request.

B. I require a leave of absence under N.J. FLA from _____ to _____
(Start Date) (End Date)

Please state the reason for your leave request in the space provided:

_____
_____
_____
_____
_____

If you are requesting leave either for the birth or adoption of a child, please provide the expected due date or date of adoption: _____

C. I request the use of accumulated paid sick days from _____ until _____ (#_____days)**

***Note:** **A leave of absence for the employee's own "serious health condition" is only covered by the FMLA.**

****Note: Accumulated sick days can only be used during the employee's own personal disability or illness.**

It is my understanding that I am eligible for up to 12 weeks of leave per 12 month period under the FMLA if I have worked at least 12 months, and at least 1,250 hours in the 12 months preceding the leave. I understand that the N.J. FLA differs from the FMLA and that under the N.J. FLA, I am eligible for 12 weeks of leave per 24 month period if I have worked at least 12 months, and at least 1,000 hours in the 12 months preceding the leave. If I am eligible for leave for reasons provided under the FMLA and N.J. FLA, then the time taken shall be concurrent and be applied to both laws. I understand that I shall notify the District as soon as practicable if dates of my scheduled leave change or are extended.

It is my understanding that upon return to the District following my leave(s), I will be reinstated to the position I held when leave commenced or to an equivalent position of like seniority, status, employment benefits, pay, and other conditions of employment.

It is also my understanding that the Board will continue my health insurance during my leave(s). I also understand that I will continue, during my leave, to pay health insurance premiums for which I may be responsible under the terms and conditions of my employment with the Board. Further, I understand that I have a minimum 30-day grace period following my receipt of an invoice from the District in which to make any such premium payments and that failure to do so may result in the cancellation of my health insurance coverage.

If leave is taken under FMLA, I understand that if I fail to return to work either after my period of leave expires, or for any reason other than the continuation, reoccurrence, or onset of a serious health condition that would entitle me to FMLA leave, or circumstances beyond my control, the Board is entitled to recover the premium that the Board paid for maintaining my health insurance coverage while on FMLA.

Further, if I fail to return to work after the expiration of the leave, I am expected to give adequate notice of same as required by the terms and conditions of my employment agreement.

I further understand that if I am eligible for New Jersey's Family Leave Insurance Program ("NJFLI"), the NJFLI benefits must be taken concurrently with leave taken pursuant to FMLA and/or N.J. FLA. NJFLI is not a leave entitlement only a monetary benefit.

I acknowledge that completion of this form, in conjunction with Board policies and regulations regarding FMLA and/or NJ FLA leave, adequately informs me of my rights and responsibilities with regard to leave under the FMLA as well as the N.J. FLA.

Employee Name: (Print) _____

Signature: _____ Date: _____