

Mountain Lakes School District

Medical/Personal Leave Request for Board Approval

Date: _____

To: Mr. Michael J. Fetherman, Superintendent
Ms. Lisa Hogan, Human Resources
School Principal

Name: _____ Title: _____

Location: _____ Signature: _____

Attached please find a doctor's note confirming my request for a: (*circle one*) medical or personal leave with an anticipated date of return on _____ (It is understood that due dates are approximate).

All leaves shall be in accordance with and in compliance with the FMLA/NJFLA and Article XVI of the ML BOE/MLEA CBA.

My first day of leave will be: _____

I have _____ sick days remaining as of _____ (date).

I am requesting to use _____ # of sick days

I am requesting to use _____ # of personal days.

Following the use of my medical/personal days, I am requesting a leave under FMLA/NJFLA.

(FMLA/NJFLA allows for up to 12 weeks including weekends and holidays: During the family leave period you will receive no pay from the Mountain Lakes School District but health coverage will remain in effect. Should you choose to continue your health benefits through Mountain Lakes Board of Education during your 12 week Family Leave, the state mandated health contribution is your responsibility. Audrey Gershey, Benefits Administrator, will provide you with the estimated cost.)

I would like my benefits coverage to continue during my FMLA/NJFLA (circle one) Yes No
_____(Please Initial)

If I would like my benefits coverage to continue during my FMLA/NJFLA, I agree to pay all applicable state-mandated health contributions to the Mountain Lakes Board of Education while on unpaid leave under FMLA/NJFLA. _____(Please Initial)

If you choose to file for NJ Family Leave Insurance visit: <http://lwd.dol.state.nj.us/labor/tdi/tdiindex.html#TDI2>
(choose Family Leave).

I am not eligible for a FMLA/NJFLA, but am requesting that the ML BOE grant my request for an unpaid leave from _____ to _____. I understand that if I have medical/prescription and/or dental coverage, I will be responsible for my premiums for the **duration of the unpaid leave of absence.***

** Employees not eligible for a FMLA/NJFLA who participate in the district benefits program are eligible for coverage under COBRA for a maximum of 18 months. (see Fact Sheet 20 for further information)*

For Office Use Only:

Sick Days: _____ Personal Days: _____

Start: _____ End: _____

FMLA/NJFLA Unpaid Leave (Yes / No)

First Day of Unpaid FMLA/NJFLA: _____ Last Day of Unpaid FMLA/NJFLA: _____

Return to Work: _____

Board Approval Date: _____