Human Resources Intermittent FMLA Request Form

Benefits & Leave Administration • 437 Old Peachtree Road, NW, Suwanee GA 30024-2978 • Fax 678-301-6111

Intermittent Leave is leave that is less than ten full consecutive days

Name ______________________________________ Employee ID # ____________________ Position ____________________
(First) (Last) (**NOT** Social Security Number)

Street Address ______________________________________ City _______________________ State _____ ZIP___________

Contact Number __________________ Personal E-mail Address ________________________ GCPS Location ____________

Estimated Leave Begin Date _______________

Expected Leave Schedule / Duration: ____

____

Intermittent FMLA

- O **Personal Illness**
- O **Maternity** - Due date _____________
- O **Adoption** - Estimated adoption date ______________
- O **Worker's Compensation**
- O **Care of newborn/adoption**
- O **Military**
- O **Illness of a family member**
  - O Spouse O Child O Parent

Additional Information

- Do you want to use accrued leave: Yes O No O
- Sick Leave Bank member: Yes O No O
- Do you have a spouse that works for Gwinnett County Public Schools? Yes O No O
- If so, provide name of spouse: __________________________ Employee ID # _______________________
- Is your spouse a Sick Leave Bank member: Yes O No O
- Comments: ____

Signature and Certification

Failure to follow leave guidelines may result in loss of all rights and privileges provided under current policy. If request is found to be fraudulent or documentation does not support your request, your approval may be revoked. Any changes of your leave must be communicated in writing to the Benefits & Leave Administration Office. If you qualify for the Family Medical Leave Act (FMLA) and your leave request is for a qualified reason, the district will use a rolling 12-month period measured backward from the date you use FMLA leave (each time you take FMLA leave, the remaining leave is the balance of the 60 working days not used during the immediately preceding 12 months).

I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT.

Employee's Signature: ____ **Date:** ______________________

Please submit this form and all supporting documentation to the Benefits & Leave Administration Office within ten calendar days of the request.

--**To be completed by Human Resources Leave Administration Office**--

FMLA eligible? YES / NO Previous FMLA used ______________ Approved _______________ Denied ____________

Comments: ____

Beginning Date of Intermittent FMLA ____________________ Leave schedule / duration / period of time:______________________

Leave Administration Signature: ____ Date: ___________________