Code: 424.1

Title: Application for Family and Medical Leave of Absence

Name ______________________________ Date of Application ________________

Location ____________________________ Department ______________________

Type of Leave Requested (check each that applies)

[ ] Medical*
[ ] Family*

Start Date (first day of leave) ______ Return Date (date of return to work) ______

Absence is to be (check each that applies): [ ] Unpaid
[ ] Paid
[ ] Partially Paid (please explain) ____________

Should vacation benefits be used? [ ] No
[ ] Yes (# of hours ________)

Reason for Requested Leave (explain why leave is necessary)

* A medical certification is required for medical/family leaves of absence. The health care provider's certification must include:

- The date the health condition began;
- The expected duration of the condition;
- Appropriate medical facts necessary to verify leave requests;
- An estimate of the amount of time required to be off work; and
- If for a family member's serious health condition, a statement that the employee is needed to care for that family member.

Employee's Signature ______________________________ Date ________________

(I understand that if I do not return from my leave of absence at the expiration of this leave, and unless an extension has been approved in advance, my employment may be terminated and/or I may be required to reimburse the School District for any contributions made by the School District during the family and medical leave and authorize the District to deduct any amount due from my final paycheck.)

Supervisor's Signature ______________________________ Date ________________

Approved: July 19, 1994 Reviewed: March 28, 2006 Revised: June 3, 1998
May 26, 2009
March 26, 2013
June 25, 2024