Darlington County School District

Medical Leave Request Form

This form is to be completed by employees or an administrator in their absence for any medical absences for self or immediate family member that requires an absence from work of three or more consecutive days, or long-term intermittent leave due to continuing medical treatment by a physician. Please submit this form 30 days prior to leave start for planned absences related to maternity or medical procedures.

Employee Name: _____ID #: _____

Job Title: _____Location: _____

Home/ Mailing Address: _____

City: _____ Zip: _____

Phone #: _____

Reason for Leave:

⬭ Birth of Child or Placement of a child for adoption or foster care (attach supporting document(s))

⬭ Serious health condition of self (attach physician's statement)

⬭ Serious health condition of immediate family member (spouse, child, or parent) (attach physician's certification

⬭ Other/ Please briefly explain: _____

Duration of Leave Requested: ___ Continuous ___ Intermittent

Leave anticipated to begin: _____Leave anticipated to end: _____

For Intermittent leave, briefly explain reason for leave and proposed schedule:

_____

_____

Type of Leave Requested to be used for absence (check all that apply):

____Accrued Medical ____Accrued Personal ____ Accrued Vacation

- Once accrued leave is exhausted, additional leave days will be at full-deduct

Short Term Disability (Leave must be exhausted before benefits are payable):

____ Yes, I am enrolled in Short Term Disability and would like to make a claim during this absence.

____ No, I do not wish to make a claim for Short Term Disability during this absence.

NOTE: 190 contracted employees must work/ be paid by the district a minimum of 152 days during an academic year to receive a full year of experience on their educator certificate.

(Complete 2nd page -Release of Information)

Release of Information (Medical Leave Request)

I am applying for Medical Leave and authorize the following physician(s) below to release information regarding the general medical reason and updated work status for my absence to the Darlington County School District Benefits office. I understand that during my absence, an update is required every thirty days if a return date cannot be determined upon the onset of the injury or illness.

Physician(s) Name: _____

Physician(s) Phone #: _____

Signature of Employee: _____Date: _____

Fax this completed form to (843)398-5006

Office Use Only:

Date Request Received: _____ Hire Date: _____

Supporting Documentation received: Yes or No _____

Response / Designation sent on: _____ Notice to L/ PR on: _____

□ FMLA protected absence □ Non FML absence

_____ _____

Benefits Coordinator *Date*