



**SANTA MARIA INDEPENDENT SCHOOL DISTRICT**  
**1111 MILITARY ROAD/PO BOX 448**  
**956-565-6308 OFFICE**  
**956-565-0598 FAX**  
**HR@SMISD.NET**

**EMPLOYEE REQUEST FOR FORESEEABLE FAMILY AND MEDICAL LEAVE**

1. Name of employee (First Name, Middle Initial, Last Name)	2. Employee's position
3. Reason for requested leave. <ul style="list-style-type: none"> <li>a. <input type="checkbox"/> Birth of a child, or placement of a child with you for adoption or foster care</li> <li>b. <input type="checkbox"/> Employee's own serious health condition</li> <li>c. <input type="checkbox"/> Because you are needed to care for your <input type="checkbox"/> spouse, <input type="checkbox"/> child, <input type="checkbox"/> parent due to his/her serious health condition</li> <li>d. <input type="checkbox"/> Because of a qualifying exigency arising out of the fact that your spouse; son or daughter; parent is on active duty or status in support of a contingency operation as a member of the National Guard or Reserves.</li> <li>e. <input type="checkbox"/> Because you are the <input type="checkbox"/> spouse; <input type="checkbox"/> son or daughter; <input type="checkbox"/> parent; <input type="checkbox"/> next of kin of a covered service-member with a serious injury or illness.</li> </ul>	
4. Date on which you wish to commence leave:	5. Date of anticipated return to work:
6. Are you requesting leave on an intermittent or reduced leave schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. If "yes," please give schedule of when you anticipate you will be unavailable for work:
<p>An employee seeking leave because of reason "3(b)" or "3(c)" above must provide medical certification within 15 calendar days.</p> <p>An employee seeking leave because of reason "3(d)" or "3(e)" above must provide qualifying exigency certification within 15 calendar days.</p> <p>An employee seeking to return to work after a leave because of his or her own serious illness [reason "3(b)"] also must provide a medical certification of ability to perform job duties before being allowed to resume work.</p>	
<p>I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expires or that I am needed to care for my spouse/parent/child because he or she has a serious health condition on the date that my leave expires. I understand that I may not be permitted to resume my position with the ESC until I provide medical certification, as appropriate.</p>	
Signed	Date