



**FAMILY MEDICAL LEAVE REQUEST (FMLA)
EMPLOYEE REQUEST**

DATE OF NOTICE: _____

Employee: _____ **Title :** _____

School/Dept: _____

Requested Start Date: _____ **Anticipated Return:** _____

Type of Leave Requested: (Circle One) Continuous Intermittent
(if request is for Intermittent, please submit proposed schedule on separate sheet)

Reason for FMLA: As FMLA benefits may include up to 60 days of unpaid leave for a 12 month period, this will be used to determine the calculation of current insurance premiums that are the employee costs.

- ____ Serious Health Condition (unable to perform essential functions of job
- ____ Serious Health Condition of ____ spouse/child/parent for which you are the sole provider for care
- ____ Birth or Adoption of Child
- ____ Immediate need arising from spouse/child/parent who is retired or reservist member, has been notified of impending call to active duty.

Once the district receives this back, your FMLA packet will be prepared for you to take to your Caregiver.

Employee _____ **Date** _____

Supervisor _____ **Date** _____