Lackland Independent School District
Employee Request for Family and Medical Leave

Type or Print

1.Name of employee (First Name, Middle Initial, Last Name)	2. Employee's position & campus or department

3. Reason for requested leave.

a. ☐ Birth of a son or daughter of the employee and to care for such son or daughter.
b. ☐ Placement of a child with employee for adoption or foster care.
c. ☐ To care for spouse, child, or parent with a serious health condition.
d. ☐ Because of employee's own serious health condition that makes him or her unable to perform job functions.
e. ☐ Because of a qualifying exigency arising out of the fact that your, spouse; child; parent is on active duty or status in support of a contingency operation as a member of the National Guard or Reserves.
f. ☐ Because you are the spouse; child; parent; next of kin of a covered service-member with a serious injury or illness.

4. If "c, e or f" please check one: ☐ Spouse ☐ Child ☐ Parent ☐ Next of kin	5. If "c, e, or f" state name and address of relation.
6. Date on which you wish to commence leave.	7. Date of anticipated return to work.
8. Are you requesting leave on an intermittent or reduced leave schedule? ☐ Yes ☐ No	9. If "yes," please give schedule of when you anticipate you will be unavailable for work.

An employee seeking leave because of reason "3(c, e, or f)" or "3(d)" above must provide medical certification or supporting documentation within 15 days. **If the FMLA leave request is foreseeable, the employee shall submit the medical certification with this request.**

An employee seeking to return to work after a leave because of his or her own serious illness [reason "3(d)"] also must provide a fitness-for-duty medical certification of ability to perform job duties before being allowed to resume work.

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 District until I provide medical certification, as appropriate.

Employee Signature _____ Date _____