TROUP COUNTY SCHOOL SYSTEM

REQUEST FOR FAMILY AND MEDICAL LEAVE

CERTIFICATION/DOCUMENTATION
EMPLOYEE/EMPLOYER IDENTIFICATION

PHONE: (706)812-7900 **100 North Davis Road, Building C, LaGrange, GA 30241** **FAX**: (706)845-4380

_____ _____
(Last Name) (First Name) (Middle Name) (Last 4 of Social Security #)

_____
(Street Address) (City/State) (Zip Code)

Signature:_____ Date:_____

Job Title: Location:

Family Leave is available to qualifying employees for the purpose of childbirth, adoption or foster care placement, care of the employee's child, spouse, parent or spouse's parent; for personal disability; military qualifying exigency leave; and military caregiver leave. See attached TCBOE Policy *GARH*.

☐ I am requesting Family Leave from: _____ to: _____

☐ I am requesting my previously approved Family Leave be extended through: _____

I am requesting Family Leave for the following reason: (check one):

- ☐ Birth of a child: Name of Mother: _____
- ☐ Adoption/Foster Care Placement: Child's Name: _____
  Date of Placement: _____ (Attach Documentation of Birth, Adoption or Foster Care)
- ☐ Personal Disability
- ☐ Care of Family Member: Name: _____
  Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Spouse's Parent

MILITARY LEAVE

- ☐ Care for injured or ill military family member (Up to a total of 26 weeks with medical documentation)
- ☐ Qualifying Exigency Leave (Up to 12 weeks with military orders and/or other supporting documentation)

Employer's Response

☐ Employee is qualified for requested leave under the Family Medical Leave Act

☐ Employee is not qualified for requested leave under the Family Medical Leave Act because:

- ☐ Employee has not been employed for the qualifying previous 12-months
- ☐ Employee has not worked the required 1250 hours during the previous 12-months
- ☐ Employee has already used the annual allotment of Family Leave

_____ _____ ☐ Approved ☐ Modified ☐ Denied
Date **Approval Signature – CHRO, Tracy Fox**

_____ _____
Date Acknowledgment of Supervisor

TROUP COUNTY SCHOOL SYSTEM

FMLA LEAVE CERTIFICATION FORMS

BIRTH OF A CHILD

Expected delivery date: _____ Your doctor must sign the Health Care Provider Information at the bottom of this form. Family Medical Leave is **unpaid** leave. However, you may choose to use any accumulated sick leave you have earned during the six weeks following childbirth. The usual and customary recovery time is six weeks after the delivery date. **After the six weeks, you will be placed on unpaid FMLA** (even if you have unused sick leave days) unless a detailed letter from your physician documents why you are not physically able to return to work.
***Employee must have physician complete a Fitness-For-Duty Report form or a signed release when cleared to return to work without restrictions.**

CARE OF FAMILY MEMBER

Name of Family Member: _____ Date(s) Employee's presence will be necessary for care of family member: Beginning Date: _____ Ending Date:_____

Describe the serious health condition of family member. Attach additional page(s), if necessary.

_____
_____

The doctor must sign the Health Care Provider Information at the bottom of this form.

EMPLOYEE ILLNESS/DISABILITY

Employee Name: _____ Describe the serious health condition that makes the employee unable to perform the essential function of his/her employment. (Attach additional page(s) if necessary) _____
_____
_____
_____

Date Disability Commenced: _____ Probable Duration or Ending Date: _____
The doctor must sign the Health Care Provider Information at the bottom of this form.
***Employee must have physician complete a Fitness-For-Duty Report form or a signed release when cleared to return to work without restrictions.**

HEALTH CARE PROVIDER INFORMATION

Physician's Name:_____ Business Name: _____

Phone Number: _____ License Number: _____

Address: _____

Date: _____ Signature of Health Care Provider: _____

ADOPTION / FOSTER CARE PLACEMENT

~~Attach Documentation of Birth, Adoption or Foster Care to this Request for Family and Medical Leave form.

MILITARY LEAVE

~~**Caregiver Leave**: Attach copy of required medical documentation for injured or ill military family member.

~~**Qualifying Exigency Leave**: Attach copy of Active Duty Orders or other military documentation.

*PREFERRED METHOD OF DELIVERY TO HR - EMAIL TO: holcombpl@troup.org (subject line: FMLA)

TROUP COUNTY SCHOOL SYSTEM
Human Resource Office
100 North Davis Road, Building C
LaGrange, Georgia 30241
PHONE: 706-812-7900 FAX#: 706-845-4380

FITNESS-FOR-DUTY REPORT

NOTE: Please return the completed form to the Human Resource Office at holcombpl@troup.org
Fax to 706-845-4380 when the doctor releases you to resume your job duties.

EMPLOYEE INFORMATION	
Employee Name	
Employee ID#	
Social Security Number	**XXX-XX-_____**
Job Title	
Location	

MATERNITY LEAVE CERTIFICATION

The individual's delivery date was _____. This is to attest that the individual named above is certified to be "Fit For Duty" and is physically able to return to work without any restrictions on _____. (The usual and customary leave for any delivery is 6 weeks.)

_____ _____
Signature of Health Care Provider Date

OTHER MEDICAL LEAVE CERTIFICATION

This is to attest that the individual named above is certified to be "Fit For Duty" and is physically able to return to work without any restrictions on _____.

_____ _____
Signature of Health Care Provider Date

PHYSICIAN/HEALTH CARE PROVIDER INFORMATION	
Physician/Health Care Provider Name:	
Business Name:	
Address:	
Phone Number:	

HUMAN RESOURCES USE ONLY:

EMPLOYEE'S INFORMATION

Job Title: _____

Hire Date: _____

Days Worked Per Year: _____ **Hours Worked Per Day:** _____

Hours Worked Over The Last 12 Months: _____