Friendswood Independent School District
REQUEST FOR MEDICAL LEAVE

Request for Medical Leave Instructions: *Page one of the request form is to be completed by the employee, make sure to complete all sections of the form. Next, the Physician Certification and a job description is sent to your health care provider to be completed. Once both forms are complete you will submit the Request for Medical Leave to Human Resources for review and approval.*

Contact: Hope Coburn, Benefits & Leave Coordinator
302 Laurel Drive, Friendswood, TX 77546
281-996-6605
Email: hcoburn@fisdk12.net
Benefits Fax: 281-996-2606
Admin Fax: 281-996-2513

EMPLOYEE INFORMATION

First Name: MI: Last Name:

Street: City: Zip:

Position: Campus or Department:

☐ Full-time ☐ art-time ☐ Hourly ☐ Bus Driver

Reason for requested leave:

☐ The birth of a child, or placement of a child with you for adoption or foster care

☐ Your own serious health condition

☐ Because you are needed to care for a family member due to his/her serious health condition

☐ spouse ☐ child ☐ parent ☐ other _____

Anticipated date leave begins: Anticipated date of return to work:

❑ PLEASE CHECK THIS BOX IF YOU HAVE SHORT TERM DISABILITY BENEFITS

NOTICE TO EMPLOYEES

* In all circumstances, it is the employer's responsibility to designate leave, paid or unpaid, as qualifying for FMLA, based on information provided by the employee.
* If approved for the Family Medical Leave, this leave will count against your annual 12 weeks of FMLA entitlement.
* In order to qualify for Family Medical Leave you must be employed at Friendswood ISD for at least 1250 hours in the previous 12 month period.
* Employees seeking medical leave must provide medical certification within 30 days. If unforeseeable, provide medical certification as soon as possible.
* All paid leave will be used concurrently with any approved medical leave, Family Medical Leave, and Temporary Disability Leave.
* Employee is required to make any additional premium payments to maintain health benefits for self or dependents and to contact the Employee Benefits Office before the leave begins to make arrangements for those payments. Health insurance coverage will cease if premium payment is more than 30 days late.
* *Employee is required to submit a physician's release to return to work if leave is due to employee's medical condition.*
* You can find a complete description of all types of leave in our district policies.

Signature **Date**

FOR FISD HR OFFICE USE ONLY:

Date request received:	Request form complete:	☐ Yes	☐ No
Hire Date:	FMLA Eligible:	☐ Yes	☐ No
☐ A job description has been given to the employee			

Attending Physician's Statement

To be completed by Physician. (Please print)

Name of Patient:	Date of Birth: / /

DIAGNOSIS

Diagnosis:
Is requested leave the result of pregnancy? ☐ Yes ☐ No
Date of delivery (if delivered): / / Expected delivery date: / /

TREATMENT

Approximate date condition commenced: / / Probable duration of condition:
Will patient need treatment appointments at least twice per year due to the condition? ☐ Yes ☐ No
Was the patient referred to other health care provider(s) for evaluation or treatment? ☐ Yes ☐ No If yes, state the nature and expected duration of treatment:
Was medication, other than over-the-counter, prescribed? ☐ Yes ☐ No
Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility? ☐ Yes ☐ No

PROGNOSIS

Please use the information provided in the attached job description to answer the following questions. If employer fails to provide a list of essential functions or a job description, please answer based upon the employee's own description of his/her job functions.

Is the employee unable to perform and of his/her job functions due to the condition? ☐ Yes ☐ No If so, identify the job functions the employee is unable to perform:
Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (including, symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment:

LENGTH OF LEAVE REQUIRED

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including time for treatment and recovery? ☐ Yes ☐ No If so, estimated dates for the period of incapacity: / / to / /
Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No If so, are the treatments or reduced work hours medically necessary? ☐ Yes ☐ No
Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from / / through / /
Will the condition cause episodic flare-ups, preventing the employee from performing his/her job functions? ☐ Yes ☐ No If yes, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months: Frequency: _____ times per _____ week(s) _____ month(s) Duration: _____ hours or _____ day(s) per episode Is it medically necessary for the employee to be absent from work during these flare-ups? ☐ Yes ☐ No If yes, please explain:

ADDITIONAL INFORMATION (if needed)

PHYSICIAN INFORMATION

Attending Physician's Name & Specialty: (print)	Telephone #: ( )	Fax #: ( )
PO Box or Street Address:	City:	State: Zip Code:

/ /

Signature **Date**