

WALLER INDEPENDENT SCHOOL DISTRICT
REQUEST FOR MEDICAL LEAVE OF ABSENCE

Name _____ Employee # _____

Address _____ Home/Cell Number _____

City _____ Zip Code _____

Campus/Department _____ Position _____

Hire Date _____ Preferred Email _____

Beginning Date of Leave _____ Return to Work Date _____

Dates are: ☐ Actual Dates ☐ Estimated Dates ☐ Intermittent Leave

Check one

Reason for Absence

Documentation Required

Employee

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Employee Illness/Medical Leave

Limited to medical leave for employee illness/surgery
FMLA guidelines apply and leave runs concurrent with other leave

Certification of Health Care
Provider with applicable dates

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Maternity/Parental Leave

FMLA guidelines apply and leave runs concurrent with other leave

Certification of Health Care Provider
with applicable dates

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Adoption or Foster Care Placements

FMLA guidelines apply and leave runs concurrent with other leave

Note from appropriate
agency

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Assault Leave – FMLA guidelines & Workman's Comp guidelines apply

See Board Policy

Family Member Illness

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Family Medical Leave (for more than 3 consecutive work days) Limited to medical leave for illness within the employee's family (as defined by District Policy)

FMLA guidelines apply and leave runs concurrent with other leave

Certification of Health Care Provider
with applicable dates

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Qualifying Exigency for Military Family Leave

Certification Form

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**Serious Injury/Illness of Covered Service Member for
Military Family Leave**

Certification Form

Employee Signature: _____ Date: _____

Principal Signature: _____ Date: _____

For Office Use Only