



**Complete forms FMLA-1 through FMLA 4. Sign and return to Human Resources at the Central Office  
(P. O. Box 350, 2194 Broad Street, Selma, AL 36702-0350)  
(P) 334-874-1600**

When the need for leave is foreseeable, the employee must apply for leave 30 days in advance. If the need for leave is unforeseen, the employee must provide such notice within 1-2 business days or when the need for leave becomes known. If the employee does not advise the supervisor or the appropriate designee that the reason for his or her leave was covered by FMLA, he or she has **two business days** upon returning to work to inform such supervisor or appropriate designee; otherwise, the employee may not subsequently assert FMLA protections. Failure to request Family and Medical Leave in a timely manner could result in the delay of your request.

You are required to furnish medical certification for a serious health condition for yourself (including pregnancy) or a family member. For your own medical leave, the certification must include information that you are or will be unable to perform one or more of the essential functions of your job.

I understand this is **unpaid leave** once all paid sick and catastrophic leave has been exhausted. I understand that my health insurance coverage will be maintained under the group health plan for the duration of the 12 weeks (60 contract days) of FMLA Leave at the same level and under the same conditions coverage would have been provided if no leave had been taken. Should I fail to return to work, the Board may recover from me the cost of any benefit coverage premium that was paid by the Board during my FMLA leave period.

I understand that FMLA is a period of 12 weeks (60 contract days), and medical/birth adoption leave may be extended up to one full year, provided my leave has not ended, and I have not been returned to payroll status. Requests for extensions/changes must be submitted to human resources in writing.

You are responsible for the timely payment of your portion of premiums for health and other benefits you elect to continue during leave. If you are in a paid status during any part of your leave, usual deductions will be made from your paycheck. If you are in an **unpaid status**, you must make arrangements to pay your usual contributions/payments.

If the premiums for insurance become past due for 30 days or more and a 15-day written notification is issued, coverage will be cancelled and cannot be reinstated until you return to paid status. Contact PEEHIP at [member.services@rsa-al.gov](mailto:member.services@rsa-al.gov), call toll-free at 877-517-0020 or call local at 334-517-7000.

**My signature below authorizes the release of my Certification of Health Care Provider and any other information needed to administer this request for Family and Medical Leave to the Selma City Schools Board of Education. I have read and understand my rights under FMLA Leave.**

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Employee Signature  
FMLA-1

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Date



**FAMILY MEDICAL LEAVE ACT  
CONFIDENTIAL INFORMATION RELEASE**

I, \_\_\_\_\_, hereby permit the Division of Human Resources, Selma City Schools, to discuss my medical condition with:

**Dr.** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

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**PLEASE RETURN via EMAIL or MAIL**

[dyphelia.thrash@selmacityschools.org](mailto:dyphelia.thrash@selmacityschools.org) [latosha.reeves@selmacityschools.org](mailto:latosha.reeves@selmacityschools.org)

**Selma City Schools-Human Resources Department, P. O. Box 350, Selma, AL 36702-0350**



**FAMILY MEDICAL LEAVE ACT CERTIFICATION OF  
PHYSICIAN OR PRACTITIONER**

Employee Name: \_\_\_\_\_

\*Patient's Name (if other than Employee): \_\_\_\_\_

\*Relationship to Employee: \_\_\_\_\_

Diagnosis:  
\_\_\_\_\_  
\_\_\_\_\_

Dates of Absence from work for this condition: \_\_\_\_\_

Probable Duration/Return to work: \_\_\_\_\_

Treatment Prescribed:  
\_\_\_\_\_  
\_\_\_\_\_

Additional  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

.....  
For certification **RELATING TO ILLNESS OF THE EMPLOYEE**, please complete the following:

- |  |     |    |
|--|-----|----|
| 1. Is inpatient hospitalization of the employee required?        | Yes | No |
| 2. Is the employee able to perform work of any kind?             | Yes | No |
| 3. Is the employee able to perform the functions of his/her job? | Yes | No |

(Answer after reviewing the statement from the employer of the essential functions of the employee's position, or after discussing with the employee)

\*For certification **RELATING TO CARE FOR THE EMPLOYEE’S SERIOUSLY ILL FAMILY MEMBER** (parent, child, etc.), please complete the following as they apply to the family member:

1. Is the employee’s presence necessary/beneficial for the care of the patient?      Yes    No
2. Probable duration of the need for the employee’s presence: \_\_\_\_\_  
.....

\_\_\_\_\_  
Signature of Physician or Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Type or Print Name of Physician)

\_\_\_\_\_  
Address

Professional Organization: \_\_\_\_\_

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**TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY MEDICAL LEAVE**

When Family Medical Leave is needed, please state the reason you will be absent and the estimated time period.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee’s Signature

\_\_\_\_\_  
Date

**PLEASE RETURN via EMAIL, or MAIL TO:**

[dyphelia.thrash@selmacityschools.org](mailto:dyphelia.thrash@selmacityschools.org)      [latosha.reeves@selmacityschools.org](mailto:latosha.reeves@selmacityschools.org)

Selma City Schools, Human Resources Department, P. O. Box 350, Selma, AL 36702-0350



## Family and Medical Leave Request Form

To: The Superintendent

From: Name \_\_\_\_\_ SSN: \_\_\_\_\_

Date: \_\_\_\_\_ School/Work Location: \_\_\_\_\_

Subject: Family and Medical Leave

Eligibility: To be eligible for Family and Medical Leave, an employee must have been employed with the Board for at least 12 months and have worked for at least 1,250 hours during the past 12 months.

Reasons: Family and Medical Leave may be requested for the following reasons:

- a) Birth of a child
- b) Care of a sick spouse, child, or parent
- c) Adoption or placement of a child
- d)   Serious health condition of an employee

I hereby request Family and Medical Leave from my official duties due to the following reason:

Birth of Child     
  Adoption of a child     
  Placement of Foster Child     
  Care of a Sick Spouse  
 Serious Personal Health Condition     
  Care of a Sick Child     
  Care of a Sick Parent

I have read the certification section of the policy and have forwarded a statement from a state-licensed medical doctor to central office personnel -  Yes  No

The expected date on which I would like to begin such leave is: (MMDDYY) \_\_\_\_\_

The date on which I expect to resume my regular duties is: (MMDDYY) \_\_\_\_\_

Conditions for use of Accrued Leave Days: For the birth of a child, adoption of a child, care of a sick spouse, child, or parent, or serious health conditions of the employee, an employee may use accrued sick leave, pe'80nal leave, or vacation days as part of FMLA Leave.

I want to use the following accumulated leave as a part of my approved Family and Medical Leave:

Number of Sick Leave days to be used	
Number of Personal Leave days to be used	
Number of Vacation Leave days to be used	
Number of Leave Without Pay days to be used	

Note: Use of accrued leave days must be approved in advance of beginning Family and Medical Leave.

I have forwarded a post-dated check to payroll for the employee paid portion of the PEEHIP group health and / or supplemental premium.  Yes  No

**I have read the Family and Medical Leave Policy, and I am making this request, being fully aware of its terms and conditions.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Superintendent Approval: \_\_\_\_\_ Date: \_\_\_\_\_