

# OTSEGO LOCAL SCHOOLS

## FMLA Leave Request Form

Employee request form for Family and Medical Leave Act leave

**Instructions:** Complete all applicable sections. This form starts the request process. The district may require additional certification or documentation before leave can be approved and designated as FMLA.

### Section 1: Employee Information

|                                           |                                        |
|-------------------------------------------|----------------------------------------|
| <b>Employee name:</b><br>_____            | <b>Position / department:</b><br>_____ |
| <b>Building / work location:</b><br>_____ | <b>Supervisor:</b><br>_____            |
| <b>Phone number:</b><br>_____             | <b>Email address:</b><br>_____         |

### Section 2: Reason for Leave

Check the reason that best describes your request. The district may request medical certification or other documentation before leave can be approved.

- ☐ Birth of a child and/or care for a newborn child
- ☐ Placement of a child for adoption or foster care and/or care for the newly placed child
- ☐ My own serious health condition that makes me unable to perform my job
- ☐ To care for my spouse, child, or parent with a serious health condition
- ☐ Military caregiver leave to care for a covered service member or covered veteran with a serious injury or illness
- ☐ Other / unsure - please explain below

Brief explanation, if needed:

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

### Section 3: Leave Dates and Schedule

|                                                                                              |                                                                                                                    |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>Requested start date:</b><br>_____                                                        | <b>Estimated return date:</b><br>_____                                                                             |
| <b>Is the leave foreseeable:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No | <b>If yes, date you first knew leave may be needed:</b><br>_____                                                   |
| <b>Will leave be continuous:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Will leave be intermittent or reduced schedule:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |

|                                                                                      |  |
|--------------------------------------------------------------------------------------|--|
| <b>If intermittent/reduced schedule, describe anticipated schedule:</b><br><br>_____ |  |
|--------------------------------------------------------------------------------------|--|

Additional schedule details:

\_\_\_\_\_

\_\_\_\_\_

Section 4: Employee Acknowledgements

**Important:** Please read this section carefully and check EACH box below. The request may be delayed if any acknowledgement is left unchecked.

- ☐ I understand that FMLA provides job-protected leave, but FMLA is not a separate paid leave benefit.
- ☐ I understand that available sick leave or other applicable paid leave may run at the same time as FMLA leave, consistent with Board policy, collective bargaining agreements, and law.
- ☐ I understand that if my paid leave is exhausted, approved FMLA leave may continue as unpaid leave.
- ☐ I understand that I remain responsible for my required employee share of health insurance premiums while on FMLA leave and must make payment arrangements if my leave becomes unpaid.
- ☐ I understand that I may be required to provide medical certification or other documentation, generally within 15 calendar days of the district’s request.
- ☐ I understand that I must keep the district informed of my status and expected return-to-work date.
- ☐ I understand that if FMLA is for my own serious health condition, the district may require a fitness-for-duty certification before I return to work.

Section 5: Employee Signature

By signing below, I certify that the information I provided is accurate to the best of my knowledge and that I will provide additional information or documentation requested by the district as needed to evaluate and administer this request.

|                             |               |
|-----------------------------|---------------|
| _____<br>Employee signature | _____<br>Date |
| _____<br>Printed name       |               |

For District Use Only

|                                  |                                                                                                                          |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| <b>Date request received</b>     | Received by                                                                                                              |
| <b>Eligibility reviewed</b>      | <input type="checkbox"/> Eligible <input type="checkbox"/> Not eligible <input type="checkbox"/> More information needed |
| <b>Certification requested</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No   Date requested: _____                                         |
| <b>Certification due date</b>    | _____                                                                                                                    |
| <b>Designation notice issued</b> | <input type="checkbox"/> Approved/designated <input type="checkbox"/> Not approved <input type="checkbox"/> Pending      |

