# JASPER COUNTY BOARD OF EDUCATION

## Request For Family Leave

**(Please type or print clearly in ink.)**
**Employee MUST complete Part 1, Part 2, AND Part 3.**
CERTIFICATION / DOCUMENTATION

***** PART 1 *****
**EMPLOYEE IDENTIFICATION**

Employee Name _____

Address _____

City, State _____ Zip Code _____

Social Security Number _____ Home Telephone Number _____

***** PART 2 *****

*Family Leave is available to qualifying employees for the purposes of childbirth, adoption, or foster care placement, care of the employee's child, spouse, parent, and for personal disability.*

_____ I am requesting Family Leave: from _____ (Beginning Date) to _____ (Ending Date)

_____ I am requesting my previously approved Family Leave be extended through _____ (Ending Date)

***** PART 3 *****

I am requesting Family Leave for the following reason:

_____ Birth of a Child - Name of mother _____

_____ Adoption / Foster Care Placement - Name of child _____; Date of placement _____

_____ Care of Family Member - Name _____; Relationship _____ Child, _____ Spouse, _____ Parent

_____ Personal Disability

**HEALTH CARE PROVIDER MUST COMPLETE CERTIFICATION ON PAGE 2.**

_____ **Employee Signature** _____ **Date of Employee Signature / Request**

SUPERVISOR'S RESPONSE

_____ Approved _____ Modified _____ Denied

_____ **Supervisor's Signature** _____ **Date of Supervisor's Signature**

# JASPER COUNTY BOARD OF EDUCATION

## Request For Family Leave

**(Please type or print clearly in ink.)**

**Health Care Provider MUST complete Part 4 AND Part 5 OR Part 6**

### ** *PART 4* **

### IDENTIFICATION OF HEALTH CARE PROVIDER

Physician's Name _____

Address _____

City, State _____ Zip Code _____

Telephone Number _____ License Number _____

### ** *PART 5* **

### CARE OF FAMILY MEMBER

Name of Family Member _____ Relationship to Employee _____

Date(s) employee presence necessary for family member: from _____ (Beginning Date) to _____ (Ending Date)

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

_____

_____

_____

_____

### ** *PART 6* **

### EMPLOYEE DISABILITY

Employee Name _____

Date The Disability Commenced _____ Probable Duration or Ending Date _____

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

_____

_____

_____

_____

_____ _____

**Signature of Health Care Provider** **Date of Health Care Provider's Signature**

# JASPER COUNTY BOARD OF EDUCATION

Family Leave

## Supervisor's Response

To: _____ Date: _____

From: _____

I have reviewed your application for Family Leave. The request is modified or denied for the reason(s) indicated below:

_____

_____

_____

_____

You have the right to appeal this decision to Ms. Tracy R. Blackburn, Jasper County Charter System Superintendent.

Your appeal, including a copy of the original request, all supporting documentation, and a copy of this letter must be filed with the person indicated above within three (3) workdays of your receipt of this decision. If you fail to file an appeal within three (3) workdays, you will forfeit all further right of appeal, including any appeal to the Board of Education.

_____ _____

**Signature of Supervisor** **Title of Supervisor**

## Response to Appeal

To: _____ Date: _____

From: _____

I have reviewed your appeal of the modification or denial of your application for Family Leave. My decision and the reason(s) for the decision is(are) indicated below:

_____

_____

_____

_____

You have the right to appeal this decision to the Board of Education. Your appeal must be filed with me within three (3) workdays of your receipt of this decision. Upon receipt of your request, I will immediately forward your appeal to the Board of Education. If you fail to file an appeal within three (3) workdays, you will forfeit any further right of appeal.

_____ _____

**Signature** **Title**