Administrative Building • 13A Dickinson Avenue • Nyack, NY 10960 • (845) 353-7000

REQUEST FOR FAMILY MEDICAL LEAVE

Employee Name: _____ Date: _____

School/Building: _____ Position/Title: _____

I request a Family Medical Leave for the following reason (check one):

_____A. The birth of a child and in order to care for such child or the placement of a child for adoption or foster care.

_____B. In order to care for an immediate family member if such family member has a serious health condition. Circle which family member: CHILD SPOUSE PARENT (Must submit "Physician or Practitioner Certification" within 15 days)

_____C. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must submit "Physician or Practitioner Certification" within 15 days)

Methods of Leave Requested

_____ A. Consecutive leave

_____ B. Intermittent or Reduced Leave Scheduled (Specify Schedule Below)

_____

_____

_____

Date leave is to begin:_____ Expected duration of leave: _____

12 weeks FMLA ends: _____

If the duration of my FMLA (total of paid and unpaid time) does not exceed 12 weeks, I will be returning to my same or equivalent position. I understand that if my FMLA should exceed 12 weeks, I will be returned to my same or similar position, only if available, in accordance with applicable laws.

_____
Employee Signature

_____
Date