Clint Independent School District Employee
Request for Family Medical Leave
FMLA Form

1. **Name of Employee: (First Name, Middle Initial, Last Name)** **|Phone#:**
2**. Employee's Position\Campus:**
3. **Reason for requested leave:** A. ☐ To care for the employee's child after birth, or placement for adoption or foster care; B. ☐ To care for the employee's spouse, child or parent, who has a serious health condition; or C. ☐ For a serious health condition that makes the employee unable to perform the employee's essential job function.

4. **Date on which you wish or intend to commence leave:**	5. **Date of anticipated return to work:**

6. **Are you requesting leave on an intermittent or reduced schedule:** ☐ **Yes** ☐ **No**
7. **If "yes" please give schedule of when you anticipate you will be unavailable:**
Employees requesting leave because of reason "3(B or C)" above will be required to provide medical certification within 15 days of employer's notice to employee. Employees seeking to return to work after a leave of absence because of their own serious illness (reason "3(C)") also **must** provide a fitness for duty certification before they are allowed to resume job duties.
Concurrent Use of Leave. Family and medical leave (FMLA) is unpaid leave. However, if you have accrued State or Local leave available, you will be required to substitute accrued paid leave days during your FMLA. **Exception for teachers only** - Under Texas Education Code (TEC) § 21.418 a teacher may elect not to take paid leave concurrently with FMLA for pregnancy, birth or adoption of a child. 8. **Teachers Only**: Are you electing to use accrued State/Local leave days: ☐ **Yes** ☐ **No Do Not Use**
I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse Clint ISD for the cost of health care benefits provided to me during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the essential job functions of my position on the date that my leave expired or that I am needed to care for my spouse/child/parent because he or she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my job duties with the District until I provide the required medical certification, as deemed appropriate by the District.

Employee Signature: _____ Date: _____

Upon completion, please forward this form to the contact below. Please direct all questions to the same contact.

Clint ISD, Benefits Coordinator
Department of Human Resources\ Benefits
14521 Horizon Blvd. El Paso, TX 79928
Phone (915) 926-4073 Fax (915) 926-4079

Received By: _____ Date Received: _____