Request for Lengthy Leave / FMLA

PLEASE PRINT Version 2010-2011

This form contains medical-related information and must be maintained in files separate from employee personnel files, in locked cabinets with only designated persons having access.

To be Completed by Employee

Name _____ Title _____

Location/School _____ Employee Payroll # _____ Date _____/_____/_____

Leave expected to begin _____/_____/_____ ; Returning to work _____/_____/_____ due to:
DATE DATE

- ❑ the birth of my child, or the placement of a child for adoption or foster care.
- ❑ a serious health condition that makes me unable to perform the essential functions for my job.
- ❑ a serious health condition, for which I am needed to provide care, affecting my (circle one)
  spouse child parent.

I am requesting to (check all that apply)

- ❑ Use accumulated sick leave and return to duty when authorized by a personal physician. Example: Maternity leave with no additional unpaid FMLA days following release to return to work.
- ❑ Use Family and Medical Leave Act of 1993 to take _____ (up to 12) weeks of unpaid leave under the guidelines and provisions of the Act
- ❑ Make written request to the Superintendent of Schools for an official "Leave of Absence" beginning _____/_____/_____.
- ❑ Resign from employment in the Irving I.S.D. effective _____/_____/_____.
- ❑ Other (Please explain) _____

Under the Family and Medical Leave Act, if you have worked at least one year and at least 1,250 hours in the past 12 months, you are eligible for up to 12 weeks unpaid leave under specific circumstances. You are entitled to receive health benefits as if you were still working. When returning to work, you must be reinstated to the same or an equivalent job with the same pay, benefits and terms and conditions of employment. If you do not return to work following FMLA leave (for a reason other than the continuation, recurrence or onset of a serious health condition which would entitle you to FMLA leave or other circumstances beyond your control), you may be required to reimburse us for our share of health insurance premiums and unearned leave paid on your behalf during your FMLA leave.

_____ _____
Signature of Employee Signature of Supervisor

SEND TO THE BENEFITS COORDINATOR, WHO WILL CONTACT YOU FOR AN APPOINTMENT

To be Completed by IISD Department of Risk Management

Appointment: Day:_____

Date:_____/_____/_____

Time:_____

☐ In Person

☐ By Telephone