Fallsburg Central School District
Family and Medical Leave Act (FMLA) Request Form

An FMLA leave of absence is a leave without pay. Paid leave (using accrued sick, personal or vacation time) shall be substituted for the unpaid leave in accordance with the Family Medical Leave Act Policy.

Employee's Name:	**Building:** Select Building	**Department:**	**Job Title:**
Initial FMLA application? ☐ **Yes** ☐ **No** **If no, list other dates applied:**			**Home Phone Number:** **Cell Phone Number:**
Leave Start Date:	**Leave End Date:**	**Are you currently on another leave? (ie: workers comp.)** **Yes** **No** **If yes, what leave?**	
Requesting intermittent or reduced work schedule? ☐ **Yes** ☐ **No** **If yes, specify the schedule requesting:**			

REASON FOR LEAVE OF ABSENCE:

☐ **The birth of a child, or placement of a child with you for adoption for foster care.**

☐ **Your own serious health condition.**

☐ **Because you are needed to care for your spouse; child; parent due to his/her serious health condition.**

☐ **Because of a qualifying exigency arising out of the fact that your spouse; son or daughter; parent is on covered active duty or call to covered active duty with the Armed Forces.**

☐ **Because you are the spouse; son or daughter; parent: next of kin of a covered service member with a serious injury or illness.**

PLEASE INDICATE YOUR SELECTION BELOW.

☐ **I will be using my accrued SICK time.** ☐ **I will use _____ sick days** *(enter number)*	☐ **I will be using my accrued PERSONAL time.** ☐ **I will use _____ personal days** *(enter number)*	☐ **I will be using my accrued VACATION time.** ☐ **I will use _____ vacation days** *(enter number)*	☐ **I request that the entire leave be UNPAID.** ☐ **I request _____ unpaid days** *(enter number)*

Employee Signature: X **Date:**

Upon the return of this form, the following forms/notifications for FMLA leave of absence will be sent to you:

☐ Certification of Health Care Provider (WH-380): This form is to be completed by either your health care provider (if this leave is for your own serious health condition) or by your family member's health care provider (if this leave is for the serious health condition of a spouse, parent, or child). Your physician must complete this entire form. ***Failure to complete this form may delay or prevent your leave approval.***

☐ Notification of Eligibility and Rights & Responsibilities (WH-381): This is to notify you of your eligibility for FMLA and your responsibilities for having the Certification form completed within 15 days of receipt and that you are required to use your paid sick, personal and vacation accruals during your FMLA absence.

☐ Continuation of Benefits While on FMLA Leave: During your FMLA leave, as long as you are being paid by using sick, personal and/or vacation days, your benefits will remain in force. If you exhaust your days before the end of the 12 weeks, you will be responsible for the employee health contribution per your bargaining unit agreement. Any unpaid leave after the 12 weeks will require payment of the full health premium amount.

☐ Request to Return From FMLA Leave: You complete the top portion of the form, the bottom portion of the form should be filled out by your Health Care Provider and returned to Central Office on the day you return to work from FMLA leave.

AUTHORIZATION STATEMENT

I understand that I am required to complete a FMLA Leave Certification of Health Care Provider form (WH-380) and submit the form to Central Office before my leave commences. I understand that if my leave is approved, my time away from work will be charged against my 12 week leave maximum under FMLA. Upon approval of this requested leave, I am required to utilize all paid time available to me prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must contact Central Office to make arrangements to pay my portion of health insurance premiums.

I understand that the Certification of Health Care Provider form (WH-380) should be returned to Central Office within 15 days. If I am not able to return the form within the allowed timeframe, I will contact Central Office for assistance.

If this information is not received in the required timeframe, my leave will be considered unauthorized.

X

Date Employee Signature

Return signed form to Central Office