

**THE SCHOOL DISTRICT OF DESOTO COUNTY
FAMILY MEDICAL LEAVE REQUEST (FMLA)
EMPLOYEE REQUEST**

Date of Notice: _____

THIS COMPLETED FORM AND CERTIFICATION OF HEALTH CARE PROVIDER (IF REQUIRED) MUST BE RECEIVED BY HUMAN RESOURCES FOR ELIGIBILITY AND APPROVAL WITHIN 15 DAYS OF THIS NOTICE

Employee: _____ SS#: _____

School/Dept: _____ Title: _____

Requested Start Date: _____ Anticipated Return: _____

Type of Leave Requested: (Circle One) Continuous Intermittent Reduced Schedule
(If request is for Intermittent or Reduced Schedule please submit proposed schedule on a separate sheet)

Reason for Leave of Absence: (check one)

- FMLA benefits may include up to 12 weeks of unpaid leave for the following in a 12-month period.
This form will be used to determine the continuation of your current insurance benefits.

___ Serious Health Condition (**unable to perform essential functions of job**)

___ Serious Health Condition of your (circle one) spouse/child/parent for which you need to provide care.

___ Birth or Adoption of child

___ Immediate need arising from your (circle one) spouse/child/parent who is a retired or reservist member, has been notified of an impending call to active duty. Not available for an employee whose family member is on active duty as a member of the Regular Armed Forces.

- FMLA benefits may include up to 26 weeks of unpaid leave in a 12 month period for the following.

___ A serious health condition affecting your (circle one) spouse/child/parent related to an injury sustained in the line of active duty for which you are needed to provide care.

An FMLA Leave of Absence is normally leave without pay. Paid leave (accrued sick and/or vacation days) shall be substituted for all or a portion of the unpaid leave in accordance with the appropriate policies. Mark one of the following:

___ I do not wish to use any accrued leave.

___ I wish to use paid leave as indicated below (place a 1, 2 or 3 to indicate order of leave request)

___ Sick ___ Personal ___ Vacation (12 mo. Employees)

Employee Signature

Date

___ You will will not be required to furnish medical certification within 15 days of this notice
(If required, Certification of Health Care Provider form must be returned within 15 days of this request).

Supervisor Signature

Date