APPLICATION FOR LEAVE
UNDER THE FAMILY AND MEDICAL LEAVE ACT

EMPLOYEE _____ POSITION _____

REQUESTED LEAVE DATES: From:_____
To:_____

If leave is requested on an intermittent or reduced leave schedule, describe the requested leave schedule:

REASON FOR LEAVE (check and complete as appropriate):

_____ A. Because of the birth of a son or daughter of mine and in order to care for such son or daughter.

_____ B. Because of the placement of a son or daughter with me for adoption or child care.

_____ C. In order to care for my spouse, son, daughter, or parent, who has a serious health care condition (name ill family member and briefly describe condition:_____
_____)

_____ D. Because of a serious health care condition that makes me unable to perform the functions of my position (briefly describe condition:_____
_____)

LEAVE ENTITLEMENT

An eligible employee must be granted up to12 workweeks of unpaid, job-protected leave in a 12-month period for specific family and medical reasons. The "leave year" for purposes of the FMLA shall be a "rolling" twelve-month period, measured backward from the date of any FMLA leave usage.

MEDICAL CERTIFICATION

If you checked Reasons C or D, you are requested to submit a written certificate from a health care provider (your ill family member's, for Reason C; your own for Reason D). The certification must be: (1) completed in substantial compliance with the Employer's "FMLA Certification of Physician or Practitioner" form, and (2) be submitted within 15 calendar days of your Application for Leave, or if such is not practicable under your circumstances, within the earliest time possible using diligent, good faith efforts. Failure to submit a sufficient timely certification may result in your leave request being denied until or unless the certificate is submitted, and if you have commenced leave before the certificate was due, in the denial of continuation of your leave and in your absence being deemed unexcused.

REPORTS DURING LEAVE

During your leave, you will be required, upon employer's request, to provide: (1) subsequent recertifications of medical certifications and (2) reports on your status and your intern to return to work.

PAID LEAVE

The employee may also have paid leave run concurrently with unpaid FMLA leave entitlement, provided all current remaining personal leave, accumulated sick leave and catastrophic leave (when applicable) days are used first.

HEALTH INSURANCE BENEFITS

Group health insurance benefits will be maintained during your leave, provided you pay the share of health plan premiums you paid prior to your leave, as may be adjusted due to changes in premium rates.

If you fail to return to work after your FMLA leave entitlement is exhausted or expires, you will owe the employer's share of health insurance premiums, to the extent permitted by the FMLA, and the employer may deduct any sums otherwise due you to recover such debt, and use other legal means to collect such debt.

FITNESS-FOR-DUTY CERTIFICATE

If you checked Reason D, you will be required, prior to returning to work, to provide a certificate from your health care provider stating, in connection with the condition that caused your leave, that you are able to return to work.

RIGHT TO RESTORATION

Upon return from FMLA leave, you are entitled to be restored to the same position you held when the leave started, or to an equivalent position. The "equivalent position" is defined by School District policy. If you qualify as a "key" employee (an employee who is salaried and is among the highest paid 10 percent of employees within 75 miles of your work site), you may be denied restoration after leave if restoration would cause substantial and grievous economic injury to the operations of the employer.

I certify that the above information given by me is correct and that I have read the foregoing and understand my rights under the FMLA.

DATED this _____ day of _____, 20____.

BY: _____
Employee

Send notices to me at: _____
_____

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ACTION ON FMLA REQUEST

Your requested leave dates from:_____ to:_____ or (if leave is request on an intermittent or reduced leave schedule, as described here: _____
_____)
are _____granted _____denied, subject to your (check if applicable) _____ submitting sufficient medical certification within 15 calendar days of the above date. Substitution of paid leave will be made as follows:

_____ Days Vacation Leave
_____ Days Personal Leave
_____ Personal Sick Leave Bank Accumulated
_____ A determination on substitution is unable to be made at this time. You will be notified when it is made.

DATED this _____ day of _____, 20____.

BY: _____
Superintendent

Date of Adoption: April 20, 2009
Revised: December 21, 2009