

# Chester Upland School District

## Family and Medical Leave Act (FMLA) Request Form

### To be completed by employee

Employee Name	School Location	Phone Number
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Job Title
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Reason for Leave of Absence <input type="checkbox"/> Own Illness <input type="checkbox"/> Care for ill parent/spouse/child <input type="checkbox"/> Pregnancy disability <input type="checkbox"/> Care for newborn/adopted child Date of birth/Placement: <input type="checkbox"/> Other (Specify)	Answer Have you been on FMLA within the last calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No  Requested Start Date:  Anticipated End Date:
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I understand that I am required to use accrued paid time off until leave concludes or accrued balance is depleted.

I understand that I am required to complete a FMLA Leave Certification of Health Care Provider form and submit the form to Human Resources 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.

You will receive the following forms for my FMLA leave of absence:

1. Certification of Health Care Provider: This form is to be completed by either my health care provider (if this leave is for my own serious health condition) or by my family member's health care provider (if this leave is for the serious health condition of a spouse, parent, or child). My physician must complete this entire form. **Failure to complete this form may delay or prevent my leave approval.**
2. Notification of FMLA Status (Approval/Denial): This is to notify me that my employer is designating the leave as FMLA leave and to inform me in writing of the specific expectations and obligations required by my employer under FMLA.

I understand that the Certification of Health Care Provider form should be returned to Human Resources within 15 days. If I am not able to return the form within the allowed timeframe, I will contact Human Resources for assistance.

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

Employee Printed Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_