

DONNA INDEPENDENT SCHOOL DISTRICT

Request for Foreseeable Family and Medical Leave (FMLA)

TO: HR Administrator

FROM: _____

Employee ID: _____

DATE: _____

RE: Request for Family and Medical Leave

If leave is being requested for a serious medical condition of a child, spouse, parent or yourself, a statement from a licensed physician confirming the serious health condition must be submitted with this request for leave.

I would like to request _____ weeks (*Maximum of 12 weeks*) of Leave under the Family and Medical Leave ACT to be used for:

I understand that under the Federal Family and Medical Leave Act, eligible employees are entitled to 12 weeks of job-protected, unpaid leave for the birth, adoption, or foster placement of a child; serious health condition of a child, spouse, or parent; or personal illness. I also understand that the District will maintain my health care benefits at the same level provided before leave began. *(If you normally pay a portion of the premiums for your health insurance, you must continue to pay for these premiums just as you did before FMLA leave. You will also need to make arrangements for payment of any additional insurances that you may have.)*

I fully understand that if the Family and Medical Leave is granted, I will be granted up to 12 weeks of leave without loss of employment benefits.

Approximate Date of Leave: _____

Approximate Date of Return: _____

Medical Certification Received: _____

Employee's Signature: _____ Date: _____

Campus/Department: _____ Position: _____

Principal/Director's Approval: _____ Date: _____

For Office Use Only!

HR Administrator's Signature: _____ Date: _____

*Forward copies to:
Principal/Director, Payroll Department, Human Resources Department*