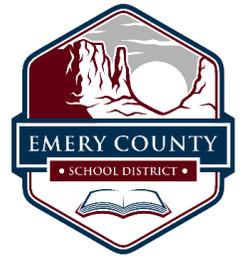


Emery County School District

Application for Family Medical Leave



Employees are entitled, under the Family and Medical Leave Act (FMLA), to take up to 12 weeks of paid or unpaid job protected leave.

Requests for Family or Medical Leave shall be made, whenever practical, at least 30 days prior to the day the requested leave is to begin.

Name _____ Date _____

Department _____ Title _____

Employment Status: Full-Time _____ Part-Time _____ Hire Date _____

REASON FOR REQUESTING LEAVE

I request family or medical leave for one or more of the following reasons:

____ Birth of my child; to care for my newborn child

____ Placement of a child with me for adoption or foster care.

____ Leave to care for a family member who has a serious health condition*

Relationship of family member to you: _____

____ My own serious health condition that makes me unable to perform my job (medical evidence required) *

Describe _____

____ Other (please explain): _____

DURATION OF LEAVE

Leave expected to begin ____/____/____ Leave expected to end ____/____/____

If an intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule: _____

Have you taken a family or medical leave in the past 12 months? ____Yes ____No

If yes, how many workdays? _____

LEAVE OF ABSENCE PAY CATEGORIES

I plan to use the following leave types:

_____ Up to 3 weeks POSTPARTUM LEAVE as allowed by Policy GEC – Postpartum and Parental Leave (if eligible)

_____ Up to 3 weeks PARENTAL LEAVE as allowed by Policy GEC – Postpartum and Parental Leave (if eligible)

_____ ANNUAL Leave _____ # of days BANKED Leave _____ # of days VACATION Leave _____ # of days

_____ Leave without pay _____ # of days *(please work with payroll dept regarding docked pay amounts)*

ACKNOWLEDGEMENT BY EMPLOYEE

I understand and agree to the following provisions:

***Medical Certification** from a health care provider is required to support a request for an employee’s own serious health condition or that of an immediate family member

A **Return to Work Certification** will be required from an employee when returning to work after the employee’s own serious health condition

I have worked for my employer for at least one year and at least 1,250 hours in the previous 12 months. If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to medical leave or other circumstances beyond my control and if my employer requires it, I will be financially responsible for the medical insurance premiums the company paid while I was on leave. I may be required to exhaust my paid vacation, personal leave or sick leave as part of my 12 weeks of leave.

I acknowledge that this FMLA request is not valid until it has been approved by Human Resource. I also understand the requirement to communicate with my supervisor and Human Resources on an ongoing basis, if there are any changes in my leave request or return to work date. After 12 weeks of leave, if I do not return to work or contact my supervisor on the date intended, it will be considered that I abandoned my job.

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

Human Resource Signature _____ Date _____

