

Skidmore-Tynan Independent School District Employee Request for Family and Medical Leave

Type or Print

1. Name of employee (First Name, Middle Initial, Last Name)	2. Employee's position & campus or department
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3. Reason for requested leave.

- a. Birth of a son or daughter of the employee and to care for such son or daughter.
- b. Placement of a child with employee for adoption or foster care.
- c. To care for spouse, child, or parent with a serious health condition.
- d. Because of employee's own serious health condition that makes him or her unable to perform job functions.
- e. Because of a qualifying exigency arising out of the fact that your, spouse; child; parent is on active duty or status in support of a contingency operation as a member of the National Guard or Reserves.
- f. Because you are the spouse; child; parent; next of kin of a covered service-member with a serious injury or illness.

4. If "c, e or f" please check one: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Next of kin	5. If "c, e, or f" state name and address of relation.
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6. Date on which you wish to commence leave.	7. Date of anticipated return to work.
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8. Are you requesting leave on an intermittent or reduced leave schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. If "yes," please give schedule of when you anticipate you will be unavailable for work.
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An employee seeking leave because of reason "3(c, e, or f)" or "3(d)" above must provide medical certification or supporting documentation within 15 days. **If the FMLA leave request is foreseeable, the employee shall submit the medical certification with this request.**

An employee seeking to return to work after a leave because of his or her own serious illness [reason "3(d)"] also must provide a fitness-for-duty medical certification of ability to perform job duties before being allowed to resume work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expires or that I am needed to care for my spouse/parent/child because he or she has a serious health condition on the date that my leave expires. I understand that I may not be permitted to resume my position with the District until I provide medical certification, as appropriate.

Employee Signature

Date