COLUMBUS INDEPENDENT SCHOOL DISTRICT

FAMILY/MEDICAL LEAVE
EMPLOYEE REQUEST FOR LEAVE FORM

1. Name of employee (Last, First, Middle Initial)	2. Employee's position

3. Reason for requested leave:

- ☐ a) the birth of your child
- ☐ b) the placement of a child with you for adoption or foster care
- ☐ c) a serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care *****
- ☐ d) a serious health condition that makes you unable to perform the essential functions of your job *** ****

4. If "c", provide name and address of relation.

5. Date on which you wish to commence leave.	6. Date of anticipated return to work.

7. Are you requesting leave on an intermittent or reduced leave schedule?

☐ Yes ☐ No

If "Yes", please give schedule of when you anticipate you will be unavailable for work.

***** Employees seeking leave because of reasons "3(c)" or "3(d)" above must provide medical certification within 15 days or as soon as practical.

****** Employees seeking to return to work after a leave because of their own serious illness [reason "3(d)"], also must provide a medical certification of ability to perform job duties **before** they are allowed to resume work.

I hereby agree that while I am on FMLA 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 FMLA leave period for a reason other than (1) the continuation, recurrence, or onset of a serious health condition which would entitle me to FMLA leave; or (2) other circumstances beyond my control, I will be required to reimburse the district for its share of health insurance premiums paid on my behalf during my FMLA leave. If I am unable to return to work because of a serious health condition, I will provide medical certification stating that I am unable to perform the function of my position on the date my FMLA leave expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date my FMLA leave expired. I understand that I may not be permitted to resume my position with the District, until I have provided medical certification, if appropriate.

Signed: _____ Dated: _____