Pleasanton Independent School District
831 Stadium Drive
Pleasanton, Texas 78064

EMPLOYEE REQUEST FOR FORESEEABLE FAMILY AND MEDICAL LEAVE

1. Name of Employee: (First Name, MI, Last Name)	**2. Employee Position:**

3. Reason for requested leave:

a. ☐ The birth of a child, or placement of a child with you for adoption or foster care.

b. ☐ Your own serious health condition.

c. ☐ To care for spouse, child, parent, because you are
☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin with a serious injury or illness.

d. ☐ Because of a qualifying exigency arising out of the fact that
☐ spouse; ☐ son or daughter; ☐ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

4. Date on which you wish to commence leave.	**5. Date of anticipated return to work.**
6. Are you requesting leave on an intermittent or reduced leave schedule? ☐Yes ☐No	**7. If "yes" please give schedule of when you anticipate you will be unavailable for work.**

An employee seeking medical leave because of reason 3(b) or 3(c) above must provide medical certification within 15 days or as practicable.
An employee seeking to return work after a leave because of his or her own serious illness {reason 3b} also must provide a 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 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 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.

Signature:_____ **Date:** _____