**INSERT School District**

**Employee Request for Family Medical Leave**

This form is to be completed by the employee when requesting Family Medical Leave. Please review the school district’s policy and procedures for Family Medical Leave and, if applicable, the Collective Bargaining Agreement for additional family medical leave information.

Qualified employees are entitled a FMLA and/or VPFLA leave of absence of up to twelve (12) weeks. This entitles employees to take a leave of absence not to exceed sixty (60) days in any twelve (12) month period. The rolling 12 month period is measured backward from the date of an employee uses any leave under leave. The employee is not entitled to 12 weeks leave for each qualifying event in a 12 month period. Additional benefits may be provided under the terms of the collective bargaining agreement.

**Employee Name:** **Location:**

**Requested Start Date:** **Estimated End Date:**

1. I hereby request approval for a family medicalleave, requested to start and estimated to end on the dates listed above, after which I intend to return to work. I expect that my need for leave during that period will be: **(mark appropriate block)**

[ ] **Continuous/Block of Time** (several consecutive days and/or weeks)

[ ] **Intermittent Basis** (Periodic time off that is not usually expected to be the same days or time off from week to week; examples may be time off for flare-ups of a medical condition and/or for ongoing medical treatments/appointments)

**(To request this type of leave, you must complete Section 6 below.)**

[ ] **Reduced Work Schedule** (A change in work schedule is needed either for fewer hours per day or fewer hours per week)

**(To request this type of leave, you must complete Section 6 below.)**

1. I am aware that, if I am eligible under federal and/or state law, (FMLA, VPFLA), I have the right:

* To take up to 12 weeks of unpaid leave in a 12-month period
* Under state law, to use, at my option, up to 30 days of any accrued paid leave, including sick and personal leave during such a leave, but that no combination of paid and unpaid leaves may extend the leave beyond 12 weeks unless otherwise provide by the collective bargaining agreement
* Under federal law, you may choose or we may require that you use accrued paid leave while taking FMLA leave.
* If you use paid leave, you must comply with our normal paid leave policies.
* Any request for an extension beyond the required Parental/Family Leave will be in accordance with the Collective Bargaining Agreement(s), Employee Handbooks and/oror Board Policies and Procedures, as applicable.
* If there is a conflict between federal and/or state law and/or the collective bargaining agreement, employee handbook and/or board policy, the benefit most generous to the employee shall be provided.
* All leave benefits, will run concurrently.
* To request other types of paid or unpaid leave, if any, in accordance with the order of leave specified in the Collective Bargaining Agreement(s).

1. I request family medicalleave for the following reason: (mark the appropriate category) (please note that not all category apply to both state and/or federal law)

[ ] the birth of your child, or your own medical condition due to your pregnancy

[ ] the placement of a child with you for adoption

[ ] the placement of a child with you for foster care

[ ] your own serious health condition/serious illness that makes you unable to perform my job;

[ ] the serious health condition/serious illness of your:

[ ] Child Under Age 18

[ ] Child 18 years or older and incapable of self-care because of mental or physical disability

[ ] Foster Child

[ ] Ward Who Resides With You

[ ] Spouse

[ ] Parent

[ ] Parent-in-Law

[ ] a circumstance for which you are requesting **short-term parental/family leave.**

[ ] A qualifying exigency arising out of the fact that your spouse, child, or parent is a military member on covered active duty (or has been notified of an impending call or order to covered active duty status).

[ ] To care for a covered service member with a serious injury or illness as you are the spouse, child, parent or next of kin of the covered service member.

[ ] other (please explain).

*Under FMLA Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms “child” and “parent” include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.*

1. I am aware, that if I am eligible, that the school district will count this leave against my parental or family leave 12 month rolling calendar entitlement under both the Family Medical Leave Act (FMLA), and/or the Vermont Parental and Family Leave Act (VPFLA) in circumstances where I qualify for leave under those statutes.
2. I am aware that I must furnish medical certification of any serious health condition or qualifying exigency that is the basis for my leave request, and that I may be required to provide re-certification as reasonably requested by my employer.

[ ] Certification of Serious Health Condition of Employee, Employee’s Family Member or Service Member of Health Care Provider form is enclosed with this request.

[ ] Certification of Serious Health Condition of Employee, Employee’s Family Member or Service Member of Health Care Provider form will be provided by (date). This day must be within 15 days of this request.

[ ] Certification of Qualifying Exigency for Military Family Leave form is enclosed with this request.

[ ] Certification of Qualifying Exigency for Military Family Leave form will be provided by (date). This day must be within 15 days of this request.

6. **INTERMITTENT LEAVE/ REDUCED SCHEDULE FOR TREATMENT:**

1. This section must be completed if an employee is requesting **Intermittent or Reduced Scheduled Leave.** Intermittent or Reduced Scheduled Leave is when:

• An employee who qualifies for Family Leave may take the leave as intermittent leave or on a reduced schedule but only if it is medically necessary, or when providing care or psychological comfort to a family member.

• An employee is granted Parental Leave after the birth or placement of a child. The school district, in its discretion, **may** grant the employee's request for intermittent leave or reduced schedule leave. Prior to the birth of a child, apregnant employee can take intermittent leave for prenatal exams or for her own medical condition.

1. I must be absent on an intermittent or reduced schedule basis because **I** or **my immediate family member (circle one)** requires medical treatment. To the best of my knowledge, the following information about the expected treatments is true.

Number of treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of post-treatment incapacitation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

You must provide the Human Resources Department with your requested new schedule to obtain approval. Your new schedule should include the approximate frequency, dates and times of leave.

1. **ELECTIONS REGARDING LEAVE / SCHEDULE ADJUSTMENT:**

Employees using FMLA or VPFLA leave must indicate whether they will elect to use any paid leave prior to the start of the leave period.

**YOU MUST INITIAL ONE OF THE FOLLOWING:**

[ ] I elect to use my paid leave balances to cover all absences. I presently have sufficient balances so that, along with accruals gained during the period of absence.

[ ] I elect to use accrued leave balances, but I will not have enough to cover all expected periods of absence. I elect to be off payroll for any absences not covered by accrued leave.

[ ] I elect not to use my accrued leave balances.

[ ] My leave is the result of a workplace injury and I am receiving payment for lost wages under the worker’s compensation insurance program. As such my leave is not considered unpaid leave. Further, no accrued leave time will be applied to this leave.

**NOTE:** All hours, paid or unpaid, that are not worked and differ from your previous work schedule will count towards your FMLA and/or VPFLA entitlement.

Employee Signature: Date:

**Please note:**

* All documentation related to family leave must be forwarded to the human resources department for record keeping. Written information related to family medical leave is considered confidential and is kept in a medical file at central office.
* If you will be requesting a leave of absence or other type of leave under the terms of the collective bargaining agreement or other board policy, you will need to submit a separate request as required by the procedures for these other types of leave.
* Additional information about your rights and responsibilities will be provided to you in writing within five school days after receipt of this notice (unless already provided).
* Determination of eligibility for leave under FMLA and/or VPFLA, and/or additional documentation or clarification of documentation may be required prior to making a final eligibility determination to approve or deny a FMLA and/or VPFLA leave request. Please contact Human Resources with any questions.

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**Please return this form and the certification form to:**

**INSERT CONTACT NAME AND ADDRESS**

**If you have any questions, please contact the above at INSERT PHONE NUMBER or INSERT EMAIL ADDRESS.**

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**For Central Office/Human Resources Use Only:**

**Date Received:**

**Date Eligibility Notice Sent:**