Application for Family or Medical Leave

Name: _____ Department: _____

Current Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave: (Explain): _____

_____

_____

_____

NOTE: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying, medical certification from a physician within 15 days of application for leave.

I hereby authorize a health care provider representing Monroe County School Board to contact my physician to verify the reason for my requested family or medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Monroe County School Board.

Signature: _____ Date: _____

APPROVED BY:

Principal/Supervisor Date

Mr. Mark T. Porter, Superintendent Date

MCSD-HR001-rev 09/14/12

Application for Family or Medical Leave
(Please Print Legibly)

Name: _____ Department/Work Site: _____

Current Address: _____

Anticipated **Start Date**: (Required)_____ **End Date** (Required): _____

Reason for Leave:

____ 1. Birth of child, to care for the newborn child.
____ 2. Placement of Foster child or adoption of child under age of 18, to care for child.
____ 3. Care for spouse, daughter, son or parent with a serous health condition.
____ 4. Employee's own serious health condition.

READ AND INITIAL EACH OF THE FOLLOWING:

Substitution of Paid Leave:

_____ I understand that if the reason for this leave is reason 1, 2, or 3, I will be required to "substitute" all payable personal and vacation leave I may have accrued and that this will be applied on the front-end of my leave.

_____I understand that if the reason for my leave is reason 1,2, or 3, that I may elect/choose to substitute a specific amount of my accrued sick leave (but not sick leave pool) and that this amount of leave shall be calculated prior to approval of this leave and will not be changeable after approval. Any substituted sick leave will be applied to the front-end of any FMLA leave I take.

- I hereby elect to take/substitute the following amount of sick leave days against my planned FMLA leave._____days.

_____I understand that if the reason for my leave is reason #4, I will be required to "substitute" all payable personal, vacation and sick leave I may have accrued and that this will be applied on the front-end of my leave.

_____ I understand that any paid leave used under any leave situation described above (1-4) shall be designated as FMLA leave and that once my allowable 12 weeks have been used in the 12-month period as defined by MCSD policy, whether paid or unpaid or a combination, my FMLA leave allowance will be completed

Medical Certification & Fitness for Duty:

_____I understand that in the event of leave for conditions 2-4, I may, upon demand, be required to provide medical certification verifying the condition for which I am seeking leave on the form approved by the MCSD and within the procedural guidelines of the MCSD FMLA leave policy.

_____ I understand that under certain conditions, including the District's right under certain circumstances to obtain second or third opinions, that my primarily health care provider may be contacted by this second or third health care professional under the guidelines of the MCSD FMLA policy, and I hereby authorize such to occur. Board to contact my physician to verify the reason for my requested family or medical leave.

_____I understand that under certain conditions I may be required to provide a "fitness to return to duty" certification should the MCSD require such, and I agree to provide such, on the approved form, if requested. ____I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the Superintendent or his designee.

Benefits & Premiums:

_____I understand that I will be responsible for the payments of any benefit premiums that come due during my leave and that failure to pay these premiums may result in the loss of those benefits.

General Acknowledgement:

I have reviewed this form and had an opportunity to ask questions concerning its contents. I am aware that this form is simply an overview of the applicable policy and that the specifics of the MCSD FMLA policy are outlined in detail within the actual policy. I am also aware that an up to date copy of the FMLA policy is available to me through the MCSD HR/Personnel office for review.

Signature: _____ Date: _____

APPROVED BY:

Principal/Supervisor Date

Mr. Mark T. Porter, Superintendent Date

MCSD0014

Request for Leave

Please Print or Type

For Office Use Only
RUN # _____
Pay Type _____

XXX-XX-
Social Security Number

In accordance with administrative regulations of the District School Board of Monroe County, I hereby request a Leave of Absence for the following period of time as indicated:

Reque

From: Time

To: Time

Number of Working Days:

Name

School/Department Position

Type of Leave Requested

☐ VACATION

☐ SICK LEAVE
____ Related to Injury-In Line of Duty

☐ PERSONAL LEAVE ____ *With Pay ____ Without Pay

*(*Explanation: If this request is submitted less than five (5) days prior to the dates requested, after the date requested or for a day before or after a holiday or recess period, an explanation of the circumstances must be provided on this form or on an attached sheet)*

☐ JURY DUTY ☐ MILITARY LEAVE

☐ FAMILY MEDICAL LEAVE- *Eligible employees may request up to twelve weeks of unpaid leave. FML application must be completed & submitted with leave request from.*

☐ EXTENDED SICK LEAVE - (Without Pay) Related to: _____ILLNESS _____ INJURY in the line of Duty
A Doctor's statement is required for any extended sick leave that exceeds 30 days

☐ OTHER:_____
Explain

☐ TEMPORARY DUTY IN-COUNTY:_____
Nature of meeting

☐ TEMPORARY DUTY ELSEWHERE: Nature of meeting _____ Location_____ –

Travel charged to:	FUND	FUNCTION	OBJECT	CENTER	PROJECT

In order to receive reimbursement for this leave, a travel voucher must be submitted to the District office within 30 days of the return date. Attach a copy of Meeting Notification and/or Agenda

Employee Signature: _____ Date: _____

Approved: _____ Date: _____
Principal/Director

Not Approved: _____ Date: _____
Principal/Director

Leave Granted: _____ Date: _____
Superintendent

Not Granted: _____ Date: _____
Superintendent