HILLSBORO R-III SCHOOLS

Family and Medical Leave Act (FMLA) Request Form

To be completed by the employee:

Employee's Name:_____ Dept/Bldg:_____

Job Title:_____ Phone Number:_____

Reason for Leave of absence:

___ Own illness ___ Pregnancy disability ___Care for newborn/adopted child

___ Care for ill parent, spouse or child ___ Other (Please specify) _____

Anticipated start date: _____ Anticipated end date: _____

Note: Paid leave (accrued sick, leave or vacation days) shall be used during your FMLA absence. This means that you will receive our paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

~I understand that I am required to have the Certification of Health Care Provider form completed by my health care provider (if leave is for my own serious health condition) or by my family member's health care provider (if this leave is for the serious health condition of a spouse, parent or child). The physician must complete the entire form. This form should be submitted to Human Resources within 15 days of the date issued. ***Failure to complete this form may delay or prevent my leave from being approved for FMLA status.***

~I understand that I am required to use accrued paid time off until leave concludes or accrued leave balances are depleted.

~I understand that my board paid benefits will continue while on FMLA leave.

~I understand that I must contact Payroll in the event that I go into an unpaid status while on leave to make arrangements to pay my portion of any elected insurance premiums, discuss "docked" pay, etc.

~I understand that I must provide "fitness to return to duty" information from my physician prior to or upon returning to work if the leave is for my own serious health condition.

~I understand that it is my responsibility to advise Human Resources when I return to work.

Employee Signature:_____ Date:_____