

**Code No. 414.3E2 CLASSIFIED EMPLOYEE FAMILY AND MEDICAL LEAVE
REQUEST FORM**

Date: _____

I, _____, request family and medical leave for the following
reason: (check all that apply)

- _____ for the birth of my child;
- _____ for the placement of a child for adoption or foster care;
- _____ to care for my child who has a serious health condition;
- _____ to care for my parent who has a serious health condition;
- _____ to care for my spouse who has a serious health condition; or
- _____ because I am seriously ill and unable to perform the essential functions of my position.

I acknowledge my obligation to provide medical certification of my serious health condition or that of a family member in order to be eligible for family and medical leave within 15 days of the request for certification.

I acknowledge receipt of information regarding my obligations under the family and medical leave policy of the school district.

I request that my family and medical leave begin on _____ and I request leave as follows: (check one)

- _____ continuous
- _____ intermittent leave for the:
 - _____ birth of my child or adoption or foster care placement subject to agreement by the district
 - _____ serious health condition of myself, parent, or child when medically necessary

Details of needed intermittent leave:

I anticipate returning to work at my regular schedule on _____ .