DECATUR INDEPENDENT SCHOOL DISTRICT
REQUEST FOR MEDICAL LEAVE OF ABSENCE

Name _____ Employee # _____

Address _____ Home/Cell Number _____

City _____ Zip Code _____

Campus/Department _____ Position _____

Hire Date _____ Preferred Email _____

Beginning Date of Leave _____ Return to Work Date _____

Dates are: ☐ Actual Dates ☐ Estimated Dates ☐ Intermittent Leave

Recommended Substitute: _____

Check one	Reason for Absence	Documentation Required
Employee		
☐	**Employee Illness/Medical Leave** (for more than 5 consecutive work days) Limited to medical leave for employee illness/surgery FMLA guidelines apply and leave runs concurrent with other leave	Certification of Health Care Provider with applicable dates
☐	**Maternity/Parental Leave** FMLA guidelines apply and leave runs concurrent with other leave	Certification of Health Care Provider with applicable dates
☐	**Adoption or Foster Care Placements** FMLA guidelines apply and leave runs concurrent with other leave	Note from appropriate agency
☐	**Assault Leave** – FMLA guidelines & Workman's Comp guidelines apply	See Board Policy
Family Member Illness		
☐	**Family Medical Leave** (for more than 3 consecutive work days) Limited to medical leave for illness within the employee's family (as defined by District Policy) FMLA guidelines apply and leave runs concurrent with other leave	Certification of Health Care Provider with applicable dates
☐	**Qualifying Exigency for Military Family Leave**	Certification Form
☐	**Serious Injury/Illness of Covered Service Member for Military Family Leave**	Certification Form

Employee Signature: _____ **Date:** _____

Principal Signature: _____ **Date:** _____

All employees must meet with the Benefits Department to discuss your leave approximately 30 days prior to your first day absent. Benefits Department 940-393-7110

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