Dundee Community Schools

Family and Medical Leave Request Form

(To be filled out by employee and returned to the Superintendent's Office)

Employee Name: _____ Date: _____

Job Title: _____Department: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) for up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. Submit this request form to your supervisor/building principal at least 30 days before the leave is to commence, when practicable. The final approval is at the Superintendent/Board level for all leaves. It is the responsibility of the employee to see that this form is secured and delivered appropriate supervisor/building principal signatures to the Superintendent for final approval. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

ELIGIBILITY: Per FMLA GUIDELINES for full-time employees.

DATES OF LEAVE REQUESTED: _____ to _____

REASON FOR REQUESTED LEAVE (Please check the appropriate box):

☐ Birth of my child and/or to care for the newborn child.
Date of birth: _____ (Attach Medical Provider Form)

☐ Placement of child with me for adoption or foster care.
Date of placement: _____(Provide Documentation)

☐ To care for my family member (spouse, child, or parent) with a serious health condition.
Relationship: _____(Attach Medical Provider Form)

☐ My own serious health condition (Attach Medical Provider Form).

I understand this is an unpaid leave. I do however intend to draw down following earned time to be paid to me while one FMLA:

☐ Sick Days _____ ☐ Vacation Days_____ ☐ Personal Days_____

EMPLOYEE STATEMENT:
I agree to return to work on _____. If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor. I understand that my benefits will continue during my FMLA leave and that I will arrange to pay my share of applicable premiums.

Following a leave because of my own serious illness, I must have my physician authorize in writing, my ability to return without any restrictions that would substantially limit me in performing my job duties.

Signature: _____ Date: _____

For Office Use Only

Approved/Denied Please confer with Business Office before final approval

_____ _____
Supervisor/Bldg.Principal Date

Date Approved by Board

_____ _____ _____ _____
Superintendent Date Date