Application for Family or Medical Leave

Name:_____School:_____

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 Red Lake School District to contact my physician to verify the reason for my requested family and 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 Red Lake School District.

Signature:_____Date:_____

APPROVED

BY: _____
Supervisor

_____
Director of Personnel

Medical Certification Statement
(Illness of Employee's Family Member)

Name of employee: _____

Name of ill family member: _____

Date condition began: _____

Date condition ended (or is expected to end): _____

Medical facts regarding the condition:

_____

_____

_____

_____

Explanation of extent to which employee is needed to care for the ill spouse, child or parent:

_____

_____

_____

_____

Will it be necessary for the employee to work intermittently or to work on less than a full schedule due to this condition? If yes, please state the probable duration:

_____

_____

If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

_____

_____

If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

_____

_____

If the treatments will be provided on an intermittent or part-time basis, provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any:

_____

_____

If any of these treatments will be provided by another provider of health services, please state the nature of the treatments:

_____

_____

Does the patient require assistance for basic medical or personal needs or safety, or for transportation? If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

_____

_____

If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____

_____

Health care provider signature:_____

Date:_____ Office Phone:_____

MEDICAL RELEASE

I authorize the release of any medical information necessary to process the above request.

Patient's signature:_____Date:_____

Medical Certification Statement
(Employee's Own Serious Illness)

Name of employee: _____

Date condition began: _____

Date condition ended (or is expected to end): _____

Medical facts regarding the condition:

_____

_____

_____

_____

Explanation of extent to which employee is needed to care for the ill spouse, child or parent:

_____

_____

_____

_____

Will it be necessary for the employee to work intermittently or to work on less than a full schedule due to this condition? If yes, please state the probable duration:

_____

_____

If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

_____

_____

If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

_____

_____

Notice of Intention to Return from Leave

Name:_____

Supervisor:_____

Date leave commenced:_____

Date of planned return:_____

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee must provide a written certification from his or her health care provider that the employee is able to resume working. [This is optional for employers.]

2. Every attempt will be made to restore an employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will placed in an equivalent position with equivalent pay and benefits.

3. An employee returning from family and medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

Employee's signature:_____

Date:_____

. . . . . .

I have examined [employee] and can certify that she/he is fully able to resume working.

Health care provider's signature:_____

Date:_____