

**LA JOYA INDEPENDENT SCHOOL DISTRICT
FAMILY MEDICAL LEAVE
EMPLOYEE REQUEST FOR LEAVE FORM**

1. Employee Name S.S.#	2. Employee's Position Campus/Department Location
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3. Reason for requested leave

a. Birth of a child, or placement of a child with you for adoption or foster care;

b. Your own serious health condition;

c. In order to care for spouse, child, or parent with a serious health condition.

d. Because of a qualifying exigency arising out of the fact that your spouse, son or daughter, parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

e. Because you are the spouse, son or daughter, parent, next of kin of a covered service member with a serious injury or illness.

4. If "c" "d" or "e" please check one: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent	5. If "c" "d" or "e" state name and address of relation
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6. Date on which you wish to commence leave.	7. Date of anticipated return to work.
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8. On what basis are you requesting leave? <input type="checkbox"/> Full time <input type="checkbox"/> Intermittent	9. If "Intermittent", please give schedule of when you anticipate you will be unavailable to work.
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Employee's seeking leave must provide medical certification within 15 days or as soon as practicable.

Employees seeking to return to work after a leave because of their own serious illness [reason "3 b"], must also provide a medical certification of ability to perform job duties before they are allowed to resume work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to meet the functions of my position on the date that my leave expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the District, until I provide medical certification, as appropriate.

Signature _____ Date _____

White: Personnel File Yellow: Payroll Pink: Campus/Department

FOR EMPLOYEE BENEFITS DEPARTMENT USE ONLY	
RESPONSE TO FMLA REQUEST:	<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED
MUST RETURN BY: _____	
Signature _____	Date _____