BARROW COUNTY SCHOOLS
REQUEST FOR FAMILY AND MEDICAL LEAVE
according to BOE Policy GBRIG
CERTIFICATION/DOCUMENTATION

(Please Print)
Social Security Number ______________________________ Date ___________________________

____
Last Name First Initial

____
Address

____
City State Zip Code

Family Leave is available to qualifying employees for the purposes of childbirth, adoption or foster care placement: care of the employee's child, spouse, parent or spouse's parent and for personal disability.

_______ I am requesting Family Leave: ______________________ _____________________
Beginning Date Ending Date

_______ I am requesting my previously approved Family Leave be extended through ______________

REASON:

_______ Birth of a Child _______ Adoption/Foster Care Placement

Name of Mother___________________ Name of Child ______________________________

Date of Birth/Placement ______________________
(Attach Documentation of Birth, Adoption or Foster Care)

_______ Care of Family Member Relationship: ______Child
______Spouse
Name _______________________ ______Parent
______Spouse's Parent

______ Personal Disability
(Health care provider must complete certification of Physician or Practitioner form)

_________________________________ _________________________
Signature of Employee/Designee Date

School System Authorization

Date first request ___________________ Sick Leave Available as of first day of leave __________________

____ ________________ __________________
Signature of Principal/Director Date Hire Date

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_____Approved ______Modified*______Denied*

*Reason ____

_____________________________________ _________________________
Signature of Superintendent/Designee Date

Return this form and the physician certification to Barrow County Schools Business Services

HCS/FML-1

BARROW COUNTY SCHOOL SYSTEM
PO Box 767
Winder, GA 30680
(770) 867-4527

Certification of Physician or Practitioner

(Family and Medical Leave Act of 1993)
and
(Barrow County BOE Policy GBRIG)

1. Employee's Name
2. Patient's Name (if other than employee)

3. Diagnosis

4. Date condition commenced
5. Probable duration of condition

6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits of treatment, if medically necessary for the employee to be off work on a intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)

   a. By Physician or Practitioner

   b. By another provider of health services, if referred by Physician or Practitioner

If this certification relates to care for the employee's seriously-ill family member, skip items 7, 8, and 9, and proceed to items 13 through 20 on reverse side. Otherwise, continue below.

Check Yes or No below, as appropriate

7. Is inpatient hospitalization of the employee required? ______Yes ______No

8. Is employee able to perform work of any kind? (If "No", skip item 9) ______Yes ______No

9. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussing with employee)

   ______Yes ______No

10. Signature of Physician or Practitioner
11. Date
12. Type of Practice (Field of Specialization, if any)

Continued on reverse side.

BARROW COUNTY SCHOOL SYSTEM

Certification of Physician or Practitioner (continued)

For certification relating to care for the employee's seriously-ill family member, complete items 13 through 17 below as they apply to the family member and proceed to item 20.

13. Is inpatient hospitalization of the family member (patient) required? ______Yes ______No

14. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety of transportation? ______Yes ______No

15. After review of the employee's signed statement (See Item 17 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) ______Yes______No

16. Estimate the period of time care is needed or the employee's presence would be beneficial.

Item 17 is to be completed by the employee needing family leave

17. When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

18 Employee Signature 19 Date

20. Signature of Physician or Practitioner 21. Date 22. Type of Practice (Field of Specialization, if any)

Please return form to: **The Employee**

or mail to: **Barrow County Schools**
Business Services
Post Office Box 767
Winder, GA 30680