



LEAVE REQUEST COVER SHEET AND ACKNOWLEDGEMENT FORM

Employee's Name: _____ Employee ID#: _____

Job Title: _____ Job Location: _____

Office Manager Name: _____ Supervisor Name: _____

Current Address (Mailing): _____

City: _____ State: _____ Zip Code: _____

Home E-mail Address: _____ Home/Cell# : _____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

Reason for Leave(Brief Explanation): _____

I have read and understand FMLA Board Policy 3430.01, which includes:

- I will submit the appropriate medical documentation at least thirty (30) days prior to the start date of my leave or as soon as practicable (within two (2) business days of learning of the need for leave); and
- I will not work in any capacity, including employment outside the District, if I have been approved for FMLA leave for my own serious health condition; and
- If I am on unpaid FMLA leave (not including disability leave) I will be required to exhaust all other paid time off (vacation, sick days, personal days); and
- If I am on FMLA leave for my own serious health condition, I will submit a fitness-for-duty certification prior to returning to work.

Employee's Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY HUMAN RESOURCES

Application Approved

FMLA: Leave Date _____ to _____

NON-FMLA: Leave Date _____ to _____

Authorized By: _____

Date: _____

NOTES:

<input type="checkbox"/> Denied
Reason _____

Coding: _____
Total # of Weeks Taken: _____

DOH: _____ CAL: _____ CAL Beg: _____ CAL End: _____

SLP: _____ DIS: _____ Return to Work: _____