THE SCHOOL BOARD OF BROWARD COUNTY, FL
REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)
Under the Family & Medical Leave Act
INSTRUCTIONAL PERSONNEL

1. All requests for **medical leave** due to your illness or the illness of a covered family member must include a completed "Certification of Health Care Provider" form.
2. All requests for **family leave** due to Adoption or Foster Care must include official notification such as a letter from the appropriate agency or attorney.
3. Military Family leave requests must include a copy of the family member's official military orders.
4. The instructional employee taking **family leave** must take a minimum of 20 unpaid days.
5. Family/Medical Leave (unpaid days used) cannot exceed twelve (12) weeks.
6. If social security and personnel numbers, dates and signatures are missing, the application cannot be processed and **will be returned.**

Name: _____ **Social Security Number:** _____

Address: _____ **Personnel Number:** _____

City/State/Zip: _____ **Daytime Telephone Number:** _____

School/Department Name: _____ **Position:** _____

REASON FOR LEAVE: *(Check One)*

FAMILY LEAVE
- ☐ Maternity
- ☐ Adoption or Foster Care
- ☐ Military Family Leave (Serious injury or illness of a current service member.)
- ☐ Military Qualifying Exigency

MEDICAL LEAVE
- ☐ Illness of Self
- ☐ Illness of Family Member
- ☐ Military Caregiver Leave (Serious injury or illness of a veteran.)

LEAVE REQUEST IS FOR THE FOLLOWING DATES:

		DATES	
NO. OF DAYS		**START**	**END**
_____	Paid Days Used	_____ –	_____
_____	Unpaid Days Used	_____ –	_____
_____	**TOTAL NO. OF DAYS**	_____ –	_____

Return to Work Date: _____
(Date should be the first workday following the end of FMLA)

EXPLANATION: (Every request must contain a brief explanation): _____

_____

_____

I understand and agree that failure to return to work at the end of my leave period will be treated as a voluntary termination of employment. If additional time is needed, I understand that I must apply for another type of leave.

Employee's Signature: _____ **Date:** _____

THE PRINCIPAL/DEPARTMENT HEAD'S SIGNATURE CONFIRMS:

- This applicant is provisionally placed on Family/Medical Leave pending review of the application, medical certificate and eligibility verification.

_____ _____

Principal/Department Head's Signature **Date**

Approved By: _____ **Date:** _____

***Division of Human Resources, The School Board of Broward County** , FL*

ROUTING INSTRUCTIONS:

School/Location forwards application and medical certification to the Leaves Department. A copy of the application will be returned after approval.