Jasper County School District
A NEW DAY... A NEW WAY...

Family and Medical Leave Form

The Family and Medical Leave Act (FMLA) became effective August 5, 1993. Leave shall be granted to eligible employees who have met the following criteria:

1) Worked at least 12 months for the Jasper County School District (JCSD); and
2) Worked at least 1,250 hours during the 12 months prior to the start of FMLA leave.
3)

Eligible employees will be granted up to a total of 12 workweeks of leave in a 12-month period for one or more of the following reasons:

1) Birth of a child;
2) Placement of a child with the employee for adoption or foster care;
3) Care of a child, spouse, or parent, who has a serious health condition; and
4) When an employee is unable to perform the function of his or her position due to a serious health condition.
5)

Eligible employees are entitled to up to 12 workweeks of unpaid family and medical leave during each consecutive 12-month period for which eligibility criteria have been met. Employees are required to substitute accrued sick, vacation, and personal leave for unpaid FMLA. The initial 12-month period is measured forward from the date the employee first takes FMLA leave. The next 12-month period begins the first time FMLA leave is taken after completion of any previous 12-month period.

Requests for FMLA leave should be made at least 30 days in advance when possible.

To be **completed by the employee** or (in the employee's absence) by the supervisor or by Human Resources based on information received from the employee.

Please print legibly

Date Submitted: _____

Employee Name: _____ Employee #:_____

S.S. #: _____

School/Dept: _____ Title: _____

Contact Information

Address: _____

Telephone #:_____ Alternate Telephone #: _____

Reason for Leave

_____ Serious illness of employee (medical certification attached)

_____ Serious illness of spouse, child, or parent (medical certification attached)

Name of individual: _____ Relationship: _____

_____ Birth of a child

_____ Placement of a child with employee for adoption or foster care (legal confirmation attached)

Anticipated date of delivery, adoption, or placement: _____

Expected Duration

Leave will be taken as (check one):

_____ A block of time from _____ to _____

(Month / Day / Year) (Month / Day / Year)

_____ Intermittently (e.g., serious health condition that requires periodic medical treatments or appointments) (Please describe on separate sheet.)

_____ Temporarily reduced work schedule (Please describe on separate sheet.)

If circumstances change I agree to notify my supervisor, for example, if I need to extend my leave, or change my schedule.

Checklist

	Yes	No	Verified by HR
1. Have you, the employee, worked for JCSD for at least 12 months. (If no, you are not eligible for FMLA.)			
2. Have you, the employee, worked at least 1, 250 hours during the previous 12 months? (If no, you are not eligible for FMLA.)			
3. Have you, the employee used any FMLA during the previous 12 months? If yes, amount of FMLA leave remaining: _____			
4. Is your spouse also an employee of JCSD? (Spouses employed by JCSD are entitled to a combined 12 workweeks of family leave for birth and care of a newborn child, and for placement of a child for adoption or foster care.)			
5. Is the reason for the leave because of your serious health condition?			
6. Is the reason for leave because of your parent's, child's or spouse's serious health condition?			
7. Is the reason for the leave because of the birth, adoption, or placement for foster care of a child by you? (This leave must conclude within 12 months of the birth or placement.)			
8. Have you included any supporting documents of your leave: medical certification or legal confirmation?			
9. I understand that my benefits will continue during my leave and that I am responsible for the employee portion of the premiums.			
10. I understand that if I fail to pay the employee portion of the premiums, my coverage will be terminated for non-payment. If this occurs I will be offered coverage under COBRA.			
11. I understand that if I have not given thirty days notice, or if I fail to fulfill any obligations to provide supporting medical certification the start of my leave may be delayed.			
12. I understand that if I do not return to work following FMLA leave for a reason other than the continuation, recurrence, or onset of a serious health condition; or other circumstances beyond my control, I may be required to reimburse JCSD for the employer portion of the premiums paid in my behalf.			
13. I understand that FMLA leave is for 12 work-weeks and that available paid leave will be substituted for unpaid leave.			
14. I understand that any misrepresentation by me in completing this form may subject me to discipline up to and including termination of my employment.			

Signatures

Employee: Telephone: Date:

Supervisor/Principal: Telephone: Date:

District: Telephone: Date:

Human Resources: Telephone: Date: