Leave Of Absence Request Form

Reason for FMLA Leave

❑ Serious Health Condition of Employee (including pregnancy)
❑ Serious Health Condition of an Immediate Family Member (parent, spouse or child)
❑ Bonding with newborn, adoption, or foster care placement
❑ Military Caregiver or Military Qualifying Exigency
❑ **NON FMLA Option** – Medical Leave / Birth Adoption Leave (includes first year care of a child)

Employee Last Name	First Name	MI	Social Security Number	Home Phone

Street Address	City	State Alabama	Zip Code

Email Address	School / Department	Supervisor Name

Number of Years (or Months) with Shelby County School System ____________

Full-time employee __________ Part-time employee __________

If leave is for a qualifying family member:	**Patient's Name:**	**Relationship to Employee:**
Is spouse SCBOE employee? ❑ Yes ❑ No	(If Yes) **Spouse's Name:**	

Requested Dates of Leave:	First day of absence:	Last day of absence:	Total length of leave:

Type of Leave: ❑ Continuous – requires physician certification (Uninterrupted block of time)

❑ Intermittent – requires physician certification (Employee takes only part of a day or takes a day off, then returns to work for a period of time, then takes another day off)

Paid Leave to be Used:	**Number of hours or days**	
Sick Leave (includes borrowed days and/or donated catastrophic days)		**Required** (will run concurrently with FMLA leave while under physician's care)
Other (Example: Comp Time)		**Required** (will run concurrently with FMLA leave)
Annual Leave (Vacation, Personal Days)		**Optional** (list only if you want to use during leave)

❑ **I elect to continue benefits during any unpaid portion of my leave. Check any that apply:**	❑ Health	❑ Dental	❑ Vision	❑ Flexible Spending

______________________________ ______________
Employee Signature Date

______________________________ ______________
Signature of Supervisor or Designee Date

______________________________ ______________
Payroll Approval Date

______________________________ ______________
Human Resources Approval Date

See Back of Form
Must Sign

Completed forms must be signed and returned to Human Resources at the Central Office (P.O. Box 1910, Columbiana AL 35051) (p) 205-682-7019 or 7042 ~ (f) 205-682-7181

When the need for leave is foreseeable, the employee must apply for leave 30 days in advance. If the need for leave is unforeseen, the employee must provide such notice within 1-2 business days or when the need for leave becomes known. If the employee does not advise the supervisor or the appropriate designee that the reason for his or her leave was covered by FMLA, he or she has **two business days** upon returning to work to so inform such supervisor or appropriate designee; otherwise, the employee may not subsequently assert FMLA protections. Failure to request Family and Medical Leave in a timely manner could result in the delay of your request.

You are required to furnish medical certification for a serious health condition for yourself (including pregnancy) or a family member. For your own medical leave, the certification must include information that you are or will be unable to perform one or more of the essential functions of your job.

I understand this is **unpaid leave** once all paid sick and catastrophic leave has been exhausted. I understand that my health insurance coverage will be maintained under the group health plan for the duration of the 12 weeks (60 contract days) of FMLA Leave at the same level and under the same conditions coverage would have been provided if no leave had been taken. Should I fail to return to work, the Board may recover from me the cost of any benefit coverage premium that was paid by the Board during my FMLA leave period.

I understand all the monies held from my paychecks for summer months will be paid to me in one pay-up check at the first payroll period after my leave begins.

I understand that FMLA is a period of 12 weeks (60 contract days) and medical/birth adoption leave may be extended up to one full year, provided my leave has not ended and I have not been returned to payroll status. Requests for extensions/changes must be submitted to human resources in writing.

You are responsible for timely payment of your portion of premiums for health and other benefits you elect to continue during leave. If you are in a paid status during any part of your leave, usual deductions will be made from your paycheck. If you are in an **unpaid** status, you must make arrangements to pay your usual contributions/payments.

If the premiums for insurance become past due for 30 days or more and a 15 day written notification is issued, coverage will be cancelled and cannot be reinstated until you return to a paid status.

My signature below authorizes the release of my Certification of Health Care Provider and any other information needed to administer this request for Family and Medical Leave to Shelby County Board of Education. I have read and understand my rights under FMLA Leave.

____________________________________ ______________________
Employee Signature Date

Additional information about Family and Medical Leave and benefits is available on Shelby County website at http://www.shelbyed.k12.al.us/hr/benefits.htm.
Forms related to Family and Medical Leave may be located on the website at http://www.shelbyed.k12.al.us/intranet/forms/internal_use.htm.