SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE

REQUEST TO APPLY FOR FAMILY AND MEDICAL LEAVE

Employee Name ____
Address____
Home Phone______________________Alternate Phone______________________
School___________________________Supervising Teacher__________________

Request is for: (Please check one)
_____ The birth or placement of a son or daughter for adoption or foster care;
_____The need to care for a spouse, son, daughter or parent of the employee because of a serious health condition *(requires medical certification);or*
_____A serious health condition of the employee that prevents the employee from performing their job functions. *(requires medical certification with an anticipated date of returning to work)*

NOTE: If FMLA is requested for the care of a seriously ill family member the following information must be provided:

Name of spouse, son, daughter or parent & explanation of relationship:

Briefly explain reason for leave request:

Anticipated dates of leave: From: Through:
(Please include a proposed schedule if you are requesting an irregular leave or leave on a reduced work schedule)

* *I certify that I have been provided information on FMLA policies & procedures.*
* *I agree to and meet the requirements and conditions of the Family Medical Leave Act of 1993.*
* *I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been requested, agreed upon and approved in writing by the agency.*

Signature____Date_____________

Request for FMLA received by: ___________________________Date_____________
Director / Assistant Director