For Human Resources Use Only:

Supervisor: _____ Eligibility Hours _____

Indianapolis Public School

HUMAN RESOURCES DIVISION

REQUEST FOR LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

Form A

I am entitled to a leave of absence under the *Family and Medical Leave Act of 1993 (FMLA).* I have received and read the **Notice to IPS Employees Requesting Leave**. I understand my obligation to notify IPS at least thirty (30) days before the date the FMLA leave is to begin. In cases of medical emergency or unexpected changes in circumstances, I must give notice as soon as practicable after I am aware that I need to take a leave of absence. I understand I am required to fill out and return the **FMLA Form A** and the **FMLA *Certification of Health Care Provider*** form, to the Human Resources Division.

Name _____ EMP. ID _____

Home Address _____ _____ **State** _____ **Zip** _____

Phone Number _____

School or Location _____

Grade, Subject or Position (if applicable) _____

I. Reason for Leave

I request FMLA leave for the following reason:

_____ (A) The birth of a child, or placement of a child for adoption or foster care on _____ (please provide date).

_____ (B) A serious health condition for which you need care.

_____ (C) A serious health condition affecting your _____ spouse, _____ child, _____ parent, for which you are needed to provide care.

Name of Family Member: _____

_____ (D) Military deployment of a: ___ child, ___ spouse, ___ grandchild, ___ sibling

_____ (E) Military injury of a: ___ child, ___ spouse, ___ grandchild, ___ sibling

Name of Family Member: _____

II. Medical Certification

I understand that my family doctor or my family member's doctor must certify the serious health condition. I must submit that certification to the IPS Human Resources Division within fifteen (15) days after I receive the application for leave.

III. Timing of Leave

_____ I request that my FMLA Leave begin on _____ and continue for complete workdays through _____.

_____ I request an intermittent or reduced schedule FMLA Leave to begin on _____, and continue for certain potions of my normal workday through _____.

IV. Election to Continue Coverage Under Other Benefit Programs

_____ I do _____ I do not want IPS to maintain my coverage under:

_____ **Medical** _____ **Dental** _____ **Life** _____ **Vision**

during the period of my leave of absence. I understand that if I elect to maintain coverage, I must make the premium payments to IPS as described in the Notice of IPS Employees Requesting Leave (Section VI).

V. Use of Accrued Paid Leave

See Notice to IPS Employees Requesting Leave (Section III).

VI. Intent to Return to Work

As a condition of job restoration, each employee must provide a written certification from his or her health care provider that the employee is able to return to work.

_____ I intend to return to work upon the expiration of this leave.

_____ I do not intend to return to work upon the expiration of this leave for the following reasons:

_____

_____

_____

_____ _____

Employee Signature Date