

Morrow County School District

Code: **GDBDA-AR(2)**
Adopted: 5/12/03

Request for Family and Medical Leave

PLEASE PRINT

Where the need for the leave may be anticipated, written request for family and medical leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin. Failure to request leave in a timely manner could result in either the leave being postponed or the amount of leave available reduced up to three weeks.

Name _____ Effective Date of the Leave _____

Department _____ Title _____

Status: Full Time Part Time Temporary

Hire Date _____ Length of Service _____

I request family or medical leave for one or more of the following reasons:¹

___ 1. Because of the birth of my child and in order to care for him or her.

Expected date of birth _____ Actual date of birth _____

Leave to start _____ Expected return date _____

___ 2. Because of the placement of a child with me for adoption or foster care. Age of child _____

Date of placement _____

Leave to start _____ Expected return date _____

___ 3. In order to care for a family member² with a serious health condition.

Leave to start _____ Expected return date _____

Please check one: ___ Spouse ___ Same-sex domestic partner (OFLA leave only) ___ Child (including the biological, adopted or foster child, child of same-sex domestic partner or stepchild of an employee or a child with whom the employee is or was in a relationship of "in loco parentis") ___ Parent (biological parent of an employee or an individual who stood "in loco parentis" to an employee when the employee was a child) ___ Parent-in-law, parent of employee's same-sex domestic partner, custodial parent, noncustodial parent, adoptive parent, foster parent (OFLA leave only.)

¹A physician's certification may be required to support a request for family and medical leave. In addition, a fitness for duty certification may be required before reinstatement following the leave.

²"Family member" means the spouse, same-sex domestic partner, custodial parent, noncustodial parent, adoptive parent, foster parent, biological parent, parent-in-law, parent of employee's same-sex domestic partner or a person with whom the employee is or was in a relationship of "in loco parentis." It also includes the biological, adopted or foster child or stepchild of an employee, child of same-sex domestic partner or a child with whom the employee is or was in a relationship of "in loco parentis."

Please state name and address of relation:

Name _____ Address _____

Describe serious health condition _____

___ 4. For a serious health condition which prevents me from performing my job functions. Describe _____

Leave to start _____ Expected return date _____

Regarding 3. or 4. above, request intermittent (reduced workday hours) or reduced leave (fewer workdays each work week) schedule or alternate duty (if applicable, subject to employer's approval). Please describe schedule of when you anticipate you will be unavailable to work: _____

___ 5. In order to care for a child with a condition requiring home care which does not meet the definition of serious health condition and is not life threatening or terminal (OFLA leave only). _____ Yes _____ No

Have you taken a family leave in the past 12 months? _____ Yes _____ No

If yes, how many workdays? _____

I understand that the district requires me to use any accrued sick leave, vacation, personal leave days or other paid time established by Board policy(ies) and/or collective bargaining agreement in the order specified by the district, and before taking leave without pay, for the family and medical leave period. Paid leave to be taken in the following order:

Serious illness – self: sick leave, personal leave, family leave

Serious illness – other: family leave, personal leave, sick leave

Parental leave – mother: sick leave (limited days), then personal leave, family leave, back to sick leave

Parental leave – father: personal leave, family leave, sick leave

Parental leave – adoption: personal leave, family leave, sick leave

If my request for a leave is approved, it is my understanding that without an authorized extension when the need for an extension could be anticipated, I must report to duty on the first workday following the date my leave is scheduled to end. I understand that failure to do so will constitute unequivocal notice of my intent not to return to work and the district may terminate my employment.

I authorize the district to deduct from my paychecks any employee contributions for health insurance premiums, life insurance or long-term disability insurance which remain unpaid after my leave, consistent with state and/or federal law.

I have been provided a copy of the district's family and medical leave policy with this family and medical leave request form.

Signature of Employee: _____ Date: _____