Emery County School District

Application for Family Medical Leave

*** Requests for Family or Medical Leave shall be made, whenever practical, at least 30 days prior to the day the requested leave is to begin ***

Name_______________________________________Date_______________________________

Department__________________________________Title_______________________________

Employment Status: Full Time __________Part Time__________Temporary__________

Hire Date______________________________________

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

___________Because of the birth of my child and in order to care for him/her.

Expected Date of Birth__/_____/_____Leave to Start__/_____/_____Expected Return Date__/_____/_____

___________Because of the placement of a child with me for adoption or foster care.

Date of Placement_____/_____/_____Leave to start__/_____/_____Expected return date___/_____/_____

___________In order to care for my spouse, child, or parent who has a serious health condition*

Leave to start___/_____/_____Expected return date___/_____/_____

___________For a serious health condition that makes me unable to perform my job (Medical evidence required)*

Describe:____

____

Leave to start___/_____/_____Expected return date___/_____/_____

___________For other reasons. Describe:____

____

Requested intermittent leave schedule (if applicable; subject to employer's approval)

____

____

Leave to start___/_____/_____Expected return date___/_____/_____

Have you taken a family or medical leave in the past 12 months (circle one)? Yes No

If yes, how many workdays? __________

I understand and agree to the following provisions:

I have worked for my employer for at least one year and at least 1,250 hours in the previous 12 months. If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control and if my employer requires it, I will be financially responsible for the medical insurance premiums the company paid while I was on leave.

This leave will be unpaid, unless it is company policy to be paid; or in the case of my own disability, payment will occur under a company disability insurance plan, if I am so covered. I may be required to exhaust my paid vacation, personal leave or sick leave as part of my 12 weeks of leave. After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

Employee Signature____Date______________________________

Leave Approval

For full day leave:
Supervisor Signature____Date______________________________

For intermittent or reduced day leave:
Supervisor Signature____Date______________________________

Human Resource Signature_______________________________________Date______________________________

Notes:____

____

____

Payroll Instructions

______With Pay from ______/______/______ To ______/______/______

______Without Pay from ______/______/______ To ______/______/______

Comments:____

____

____

____

____