

Ellwood City Area School District
Family & Medical Leave Act (FMLA) Request Form For Professional Employees

To be completed by the Employee:

Name _____ Home/Cell Phone _____

Current Position _____ Current email _____

An FMLA Leave of Absence is a leave without pay. Paid leave (using accrued sick days or vacation days) may be and in certain circumstances shall be substituted for the unpaid leave in accordance with District Policy 335 Family and Medical Leaves.

FMLA LEAVE REQUESTED

I request leave from _____ (requested start date) to _____ (anticipated return date).

I request intermittent or reduced schedule leave according to the following schedule:

Have you taken an FMLA leave in the past 12 months? Yes No Dates of prior leave: From _____ to _____

I am requesting FMLA Leave for the following reason:

- My own personal serious health condition
- To care for the serious health condition (Practitioner or Physician certification may be required) of:
 - Spouse
 - Child
 - Parent
- The birth of my child and to care for such child (Expected date of birth: _____)
- The placement of a child with me for adoption or foster care (Expected date: _____)
- Military caregiver leave to care for a covered service member with a serious injury or illness: Name: _____
- Qualifying exigency leave due to the fact that my spouse, child or parent is in active duty military service in a foreign country or has been notified of an impending call or order to active duty military service in support of a contingency operation: Name: _____

I understand that pursuant to the Memorandum of Understanding between the District and EAEA dated April 15, 2016 and District Policy No. 335, (a) I may use accrued paid leave not to exceed the lesser of 20 days or the amount of accrued paid leave available to me prior to commencing any requested FMLA leave, (b) I will then be on unpaid FMLA Leave except that I am required to use any remaining accrued paid leave, except for 10 days, until my FMLA Leave ends or all of my accrued paid leave is depleted, (c) although I am not required to use the last 10 days of accrued paid leave simultaneously with the unpaid FMLA Leave, I have the option to do so, and (d) upon depletion of all of my accrued paid leave, I may, but am not required, to use up to 20 days of paid sick leave less the cost of a substitute. Below is an estimate of the accrued paid leave available to me.

Accrued sick leave _____ days
Accrued vacation _____ days
Accrued compensatory time _____ days
Unused sick days less cost of the substitute _____ days

I am requesting use of accrued paid leave as follows:

Amount of intended initial paid leave (non-FMLA Leave): _____ days [not to exceed the lesser of 20 days or the total accrued paid leave available to me]

If available to me, I ___ do / ___ do not intend to use my remaining 10 days of accrued paid leave. [check one]

If available to me, after exhaustion of all accrued paid leave, I ___ do / ___ do not intend to use up to 20 days of paid leave less the cost of a substitute. [check one].

Amount of intended paid leave less the cost of a substitute: _____ days [not to exceed 20 days]

I understand that the District may require a Certification of Health Care Provider in certain circumstances depending upon the reason for my requested leave. I have read and understood District Policy 335. I certify that the above information is true, correct and complete.

Employee Signature: _____ Date: _____

Return this form to the District's Business Office.