

Southfield Public Schools

FAMILY MEDICAL LEAVE REQUEST FORM - (FMLA)

Directions for applying for Leave under FMLA:

- Employee completes this request form and gives to their Supervisor/Building Administrator to sign. The form then is sent to Teresa Foster in Human Resources.
- Please ensure that the Absence Management System is updated with your absence (if required).
- For questions and submission of forms contact Teresa Foster (248) 746 – 8547 or fax (248) 746 – 8926.

After receipt of all documents and review, you will be notified as to the status of your leave request.

| | | |
|---|---|---------------|
| Employee's Name: | | Telephone #: |
| Address: | | |
| Do you consent to receiving emails from HR during leave/FMLA via your District e-mail? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| If not, please provide an alternative e-mail: | | |
| Position: | | Job Location: |
| Hire Date: | Have you used FMLA leave days in the past 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO | |

REASON FOR REQUEST: (Check one)

| | | |
|--|--|---|
| <input type="checkbox"/> | Birth of Child (Requires Form WH380E or WH380F) | Due Date (MM/DD/YYYY): |
| <input type="checkbox"/> | Placement for Adoption/Foster Care (Requires FMLA Leave Request – Legal Placement Documentation) | |
| <input type="checkbox"/> | Serious Health Condition of Employee (Requires Form WH380E) | |
| <input type="checkbox"/> | Care for seriously ill family member (Requires Form WH380F) Name: | Relationship: (Age if Dependent) |
| <input type="checkbox"/> | Military Family (Exigency) Leave Name: | Relationship: |
| <input type="checkbox"/> | Military Care Giver Leave Name: | Relationship: |
| Tentative date Leave is to begin: | | Tentative Date you expect to return to work: |
| <i>**Dates on the signed Physician Certification Form will serve as the recorded confirming leave dates rolling forward</i> | | |

Are you requesting Continuous Family Medical Leave (up to 12 weeks in succession) ___yes ___no

Are you requesting Intermittent Family Medical Leave (12 weeks spread out over a 12 month period, rolling forward) ___yes ___no

I understand that:

- During my FMLA-eligible period of **paid** leave, my benefits will continue
- For **unpaid leave only**: information on continuing premium payments must be requested from Teresa Foster as above.
- I am responsible for notifying my employer immediately, in writing, of any changes(s) in the leave period.
- I must provide a medical clearance to return to work after a personal illness leave of 5 days or more

| | | |
|------------------------------------|-------------|-------|
| Employee's Signature: | | Date: |
| Manager Acknowledgement Signature: | Print Name: | Date: |