

**MONTABELLA COMMUNITY SCHOOLS
FAMILY MEDICAL LEAVE ACT (FMLA) REQUEST FORM**

EMPLOYEE'S NAME _____ SSN _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

BUILDING _____ JOB TITLE _____

ADMINISTRATOR _____

PURPOSE OF LEAVE (Check One)

____ Employee's Personal Illness – Type of Illness _____

____ Childbirth ____ Adoption ____ Foster Child Anticipated date _____

____ Care of Seriously Ill Family Member (Employee's Parent, Spouse, or Child)

Name of Family Member _____ Relationship _____

Type of Care Required _____

FMLA BEGINNING DATE _____ FMLA ENDING DATE _____

(Please be advised that sick leave, personal and vacation days must be taken concurrently with FMLA period.)

If leave is to be taken intermittently or if there will be a reduced work schedule, describe the schedule.

I certify that the information above is accurate. I understand that I will need to provide necessary medical documentation for any period of FMLA requested and that I will need to notify my department and/or Central Office **immediately** if any of the information above should change.

EMPLOYEE _____ DATE _____

As the supervisor of the employee listed above, I am aware that the employee has applied for a Family Medical Leave Act leave. I understand that any leave taken must also be posted concurrently against the FMLA accrual. I will notify the Central Office **immediately** if I become aware of any changes to the information above.

ADMINISTRATOR _____ DATE _____