FAMILY MEDICAL LEAVE APPLICATION
(LEAVE WITHOUT PAY)
Maximum: Twelve Weeks

NAME:_____ SOC. SECURITY # ____/____ /____

ADDRESS:_____ PHONE_____

_____
City State Zip Code

LOCATION (School):_____ POSITION:_____

IF TEACHER, grade **and/or SUBJECT:** _____

REASON FOR LEAVE: _____

_____

_____

LAST DAY YOU WILL WORK: _____

EFFECTIVE DATE OF FAMILY LEAVE: _____

DATE YOU WILL RETURN TO WORK: _____

SIGNATURE OF EMPLOYEE:_____

DATE REQUESTED:_____

_____
Jacklene Jones, Director of Human Resources (signature)

DATE REVIEWED:_____

A PHYSICAN'S STATEMENT MUST BE ATTACHED TO MEDICAL LEAVES. A RETURN TO WORK RELEASE MUST BE OBTAINED FROM PERSONNEL OFFICE PRIOR TO RETURNING TO WORK AFTER DOCTOR HAS OFFICIALLY GIVEN YOU A WRITTEN RELEASE