

Request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

Name: _____ Date: _____

Department: _____ Title: _____

Status: Full Time/Part Time/Temporary Employee Payroll Number/Campus: _____

Hire Date: _____ Length of Service: _____

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

- Because of the birth of my child and in or to care for him or her:
Expected date of birth _____ Actual date of birth _____
Leave to start on _____ 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. * Describe:

Leave to start _____ Expected return date _____
(*Physician certification will be required for leave.)

- For other reason:
Describe _____

Leave to start _____ Expected return date _____
- Requested intermittent leave schedule. This will be subject to VISD approval.
Describe _____

Have you taken family medical leave in the past 12 months? Yes/No

I understand and agree to the provisions below:

- I have worked for my employer at least one year and at least 1250 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 FMLA or other circumstances beyond my control. If my employer requires it, I will be financially responsible for entire medical premiums and all other benefits the company paid while I was on leave.
- This leave will be unpaid, unless it is company policy to be paid; or in 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 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 considered that I abandoned my job.

Employee Signature: _____ Date: _____

Employee Name: _____ Campus: _____

Leave Approval

For Full Day Leave:

Manager/Supervisor Signature: _____ Date: _____

For Intermittent or Reduced Day Leave:

Manager / Supervisor Signature: _____ Date: _____

Assistant Superintendent of Human Resources Signature _____ Date: _____

Notes:

Payroll Instructions

- With Pay from _____ to _____
- Without Pay from _____ to _____

Comments: _____
