Print Form

COLDSPRING – OAKHURST CISD
EMPLOYEE REQUEST FOR FAMILY & MEDICAL LEAVE

Type or Print

1. Name of Employee (First, Middle Initial, Last)	2. Employee's Position

3. Reason for requested leave.

__ a. Birth of a son or daughter of the employee and to care for such son or daughter.
__ b. Placement of a son or daughter with employee for adoption or foster care.
__ c. To care for spouse, child, or parent with a serious health condition.
__ d. Because of employee's own serious health condition that makes him/her unable to perform job functions.

4. If "c", please check one.	5. If "c", state name and address of relation
__ Spouse __ Child __ Parent	Name:_____ Relation:_____
6. Date on which you wish to commence leave.	7. Date of anticipated return to work.
8. Are you requesting leave on an intermittent or reduced leave schedule ? __ Yes __ No	9. If "yes", please give schedule of when you anticipate you will be unavailable for work.

An employee seeking leave because of reason "3. (c)"or "3.(d)" above must provide medical certification within 15 days or as soon as practicable.

An employee seeking to return to work after a leave because of his or her own serious illness (reason 3d.) also must provide a medical certification of ability to perform job duties before being allowed to resume work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expires or that I am needed to care for my spouse/parent/child because he or she has a serious health condition on the date that my leave expires. I understand that I may not be permitted to resume my position with the District until I provide medical certification, as appropriate.

Signed:_____ Dated: _____

After completing return to: Human Resources