

REQUEST FOR FAMILY/MEDICAL LEAVE

EMPLOYEE NAME: _____ DATE OF REQUEST: _____
DEPARTMENT: _____ POSITION TITLE: _____
HIRE DATE: _____

I request a Family/Medical Leave for the following reason (check one):

- _____ A. The birth of a child and in order to care for such child or the placement of a child for adoption or foster care.
- _____ B. In order to care for an immediate family member if such family member has a serious health condition. Circle one: CHILD - SPOUSE - PARENT
(Must submit "Physician or Practitioner Certification" within 15 days)
- _____ C. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. (Must submit "Physician or Practitioner Certification" within 15 days)

Methods of Leave Requested

- _____ A. Consecutive Leave
- _____ B. Intermittent or Reduced Leave Schedule (Specify Schedule Below)

Date leave is to begin: _____ Expected Duration of Leave: _____
12 Weeks of FMLA ends: _____

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks I will be returned to my same or similar position, only if available, in accordance with applicable laws.

**Return to: Human Resource Department
South Colonie Central Schools
102 Loralee Drive
Albany, NY 12205
(518) 869-3576 ext. 2470 or 2474**

Employee Signature

Date