Please read and sign below

PASADENA INDEPENDENT SCHOOL DISTRICT

FAMILY MEDICAL LEAVE EMPLOYEE REQUEST FOR LEAVE FORM

Type or Print and Submit to Human Resources

HUMAN RESOURCES OFFICE USE ONLY

Authorization ____________ FMLA Effective Date ____________

G 6-5
rev. 3/09

1. Name of employee (First Name, Middle Initial, Last Name)	Employee ID #	2. Employee's Position/Location

3. Date Leave Starts:	**4. Date of anticipated return to work:**

5. Reason for requested leave

a. ☐ Birth of a son or daughter of the employee and in order to care for such son or daughter

b. ☐ Placement of son or daughter with employee for adoption or foster care

c. ☐ In order to care for a family member with a serious health condition

Please indicate one: ☐ Spouse ☐ Child ☐ Parent ☐ Other ____________

Name and address of person indicated above: ____________

d. ☐ Because of employee's own serious health condition that makes him/her unable to perform job functions

e. ☐ Because of a serious injury/illness of a covered service-member

f. ☐ Because of a qualifying exigency for military leave

Employees seeking leave because of reason 5c or 5d or 5e or 5f must provide medical certification within 15 days or as soon as practicable.

Employees seeking to return to work after a leave because of their own serious illness (reason 5d) must also provide a medical certification of ability to perform job duties before they are allowed to resume work.

6. Are you requesting leave on an intermittent or reduced leave schedule? ☐ Yes ☐ No

7. If "Yes" to question 6., please give schedule of when you anticipate you will be unavailable for 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 the continuation, recurrence, or onset of a serious health condition or because of other 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 expired or that I am needed to care for my spouse/parent/child because he/she has a serious condition on the date that my leave expired.

FAMILY AND MEDICAL LEAVE: YOUR RIGHTS AND OBLIGATIONS

1. All time taken as a result of this leave will count against your annual Family Medical Leave entitlement.
2. You will be required to submit this completed *Family Medical Leave Certification Form* before the leave begins or, if the need for leave is unforeseen, as soon as practicable. Failure to provide this certification may result in denial of leave until such Certification is provided, as well as disciplinary actions up to and including termination.
3. If you take a Family Leave for the birth or adoption of a child, you will be required to exhaust all of your accrued but unused personal leave, vacation or other paid family leave time during your Family Leave. After you have exhausted all such paid time off, whatever time remains of your 12 weeks of Family Leave will be without pay.
4. If you take a Family Medical Leave because of your own illness, or to care for a seriously ill family member, you will be required to exhaust all of your accrued but unused personal leave, vacation, sick leave or other paid medical leave during your Family Medical Leave. After this paid time off is exhausted, whatever time remains of your 12 weeks of Family Medical Leave will be without pay.
5. You will remain active in the group health insurance program. The District will continue to pay the percentage of premiums normally paid for by the District and you will be responsible for continuing to pay your regular portion of the premiums for group health insurance coverage.
6. When you return from a Family Medical Leave you will be required to provide a Certification from your physician or health care provider stating that you are able to return to work. You may not return to work before such verification is provided.
7. When you are on a Family Medical Leave, you will be required by the District to periodically provide information on your status and on your intention to return to work. Failure to provide such information may subject you to disciplinary actions up to and including discharge for voluntary job abandonment.

PENALTIES FOR FAILURE TO RETURN FROM A FAMILY LEAVE OR MEDICAL LEAVE

The District may recover the group health care premiums paid for by the District on your behalf during a Family Leave or Family Medical Leave if you fail to return to work after the allowable amount of Family Leave and/or Family Medical Leave time expires unless you are unable to return due to the continuance or recurrence of the serious health condition or unless you are unable to return to work for other reasons beyond your control.

I hereby certify that the information provided above is true and complete. I also certify that I have read and understand the above rights and obligations associated with my Family Medical Leave.

Employee's Signature X ____________ Date ____________

Witness Signature **(If Applicable)** ____________ Date ____________

White copy: Certified Services ____ Support Services *Yellow copy: Employee* *Pink copy: Work Location*