

**WINDHAM SCHOOL DISTRICT
FAMILY/MEDICAL LEAVE
EMPLOYEE REQUEST FOR LEAVE FORM**

Type or Print

1.Name of employee (First Name, Middle Initial, Last Name):	2.Employee's position:
3.Reason for requested leave: <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Serious health condition of: <input type="checkbox"/> spouse, <input type="checkbox"/> child; or <input type="checkbox"/> parent condition: <input type="checkbox"/> Employee's own serious health condition:	4.Are you requesting leave on a: <input type="checkbox"/> Full-time basis <input type="checkbox"/> Intermittently If intermittent, give projected schedule:
5.First date you expect to be out for this medical reason:	6.Projected return to work date:
<p style="text-align: center;">Item 7 is to be completed by employees who need Family/Medical leave for a family member:</p> 7.State the type of care and assistance you will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:	
<p>Employees seeking leave due to the serious medical condition (employee's or a family member) must provide medical certification within 15 days or as soon as practicable.</p> <p>Employees seeking to return to work after a leave because of their own serious illness must also provide a medical certification of the ability to perform job duties from the appropriate health care provider before they are allowed to resume work.</p>	
<p>I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums less the state contribution, 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 fax medical certification form the appropriate health care provider stating that I am unable to perform the functions of my position every 30 days until my leave expires or that I am needed to care for my spouse/child because he/she has a serious health condition through the date that my leave expires to (936) 291-4622. I understand that I will not be permitted to resume my position with the District until I provide medical certification, as appropriate.</p> <p>Signed: _____ Dated: _____</p>	