

# Family & Medical Leave Request

_____ ▲ Employee's Name (please print)	_____ ▲ Employee's Work Location
_____ ▲ Employee's Job Title	_____ ▲ Date

I request a Family/Medical Leave in accordance with the Family and Medical Leave Act (FMLA) for the following reason(s):

- Family Leave for the birth of my child and care for my child after birth (FMLA leave cannot extend beyond age 1)
- Family Leave for the placement of a child with me for adoption or foster care (FMLA leave cannot extend beyond 12 months after the placement)
- Medical Leave to care for my spouse, child, or parent who has a serious health condition.\*
- Medical Leave for my own serious health condition which renders me unable to perform my job.\*

*\* Note: Medical Certification is required for Medical Leave. Such certification must be provided within 15 days of the request for leave. Medical Certification forms are available from the Personnel Office.*

For leave to be taken all at once rather than on an intermittent or reduced work week basis:

_____ ▲ Date Leave is to Start	_____ ▲ Date Leave is to End
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For leave to be taken on an intermittent or reduced work week basis, please list schedule of time needed off. (Note: An employee may take Medical Leave on an intermittent or reduced work week basis when medically necessary. An employee may take Family Leave on such basis only with the approval of the District Superintendent or designee.)

\_\_\_\_\_  
\_\_\_\_\_

I have been provided a copy of OCM BOCES Board Policy 5341 and/or applicable provision of my collective bargaining agreement governing FMLA Leave. I understand that my absence of four (4) or more consecutive days for personal illness (paid or unpaid) and any previous FMLA leave occurring from July 1 of this fiscal year to the effective date of this request for FMLA leave will be subtracted from my total annual fiscal year FMLA leave entitlement. I understand I will be required to substitute accrued paid sick leave for medical leave for my own serious health condition and I understand I will be required to pay my share of the premium rate for group health and dental insurance coverage.

_____ ▲ Employee Signature	_____ ▲ Date
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**Personnel Department Use Only**

office  
 teacher  
 mos. \_\_\_\_\_ %  
 ▲ Work Year      ▲ Calendar      ▲ FTE

▲ Employee's Name \_\_\_\_\_

\_\_\_\_\_  
 ▲ Date of Leave      Employee <sup>(circle one)</sup> has/has not worked for at least 12 months preceding commencement of leave.

\_\_\_\_\_  
 ▲ Date of Employment      Employee <sup>(circle one)</sup> has/has not worked at least 1,250 hours during 12 months preceding commencement of leave.

Maximum FMLA Leave: \_\_\_\_\_ 60 work days  
 FMLA Leave taken during this fiscal year: \_\_\_\_\_ work days  
 FMLA Leave available: \_\_\_\_\_ work days  
 FMLA Leave this request ( \_\_\_\_\_ ): \_\_\_\_\_ work days  
    ▲ Date Start      ▲ Date End

FMLA Leave remaining: \_\_\_\_\_ work days

**Type FMLA Leave:**

Medical Leave (ML): \_\_\_\_\_  
    Date(s)  
 Medical Cert. Rcvd.: \_\_\_\_\_  
    Date  
 Family Leave (FL): \_\_\_\_\_  
    Date(s)

**Accrued leave to be substituted for FMLA Leave:**

Sick Leave (ML): \_\_\_\_\_ # of Days  
    Date(s)  
 Sick Leave Bank (ML): \_\_\_\_\_ # of Days  
    Date(s)  
 Personal Business Leave (ML, FL): \_\_\_\_\_ # of Days  
    Date(s)  
 Family Leave (ML): \_\_\_\_\_ # of Days  
    Date(s)  
 Vacation: \_\_\_\_\_ # of Days  
    Date(s)  
 Leave Without Pay: \_\_\_\_\_ # of Days  
    Date(s)

**Total Leave** \_\_\_\_\_  
 # of Days

**Insurance Coverage:**

	<i>Employee's</i>					
	<i>Bi-Weekly Contribution</i>		<i>Required Contributions</i>			<i>Total Contribution</i>
<input type="checkbox"/> Individual Health:	\$ _____ . _____	X	_____	=	\$ _____ . _____	
<input type="checkbox"/> Family Health:	\$ _____ . _____	X	_____	=	\$ _____ . _____	
<input type="checkbox"/> Individual Dental:	\$ _____ . _____	X	_____	=	\$ _____ . _____	
<input type="checkbox"/> Family Dental:	\$ _____ . _____	X	_____	=	\$ _____ . _____	

Leave Approved       Leave Denied – Reason: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 ▲ Signature – Director, Personnel and Labor Relations      ▲ Date