



Minnesota Valley Education District #6027

REQUEST FOR FAMILY MEDICAL LEAVE OR MEDICAL LEAVE

Name: _____ Date: _____

_____ I am requesting Family and Medical Leave or Medical Leave for the following period

Start Date: _____ through End Date: _____

OR

_____ I am requesting leave in the form of intermittent leave or reduced hours as follows (specify starting and ending dates and the hours to be taken as leave): _____

	This leave is requested for:
	Birth of a child
	Caring for a newborn child
	Caring for a child placed for adoption or foster care
	Caring for a family member with a serious medical condition: (circle as appropriate: spouse, child, parent)
	My own serious medical condition
	Military Family Leave because of a qualifying exigency (12-week maximum)-- <u>Attach Certification of Qualifying Exigency for Military Leave form</u>
	Military Family Leave to care for a covered servicemember with a serious injury or illness (26-week maximum)-- <u>Attach Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave form</u>

I will use leave provided for in my contract (sick and/or personal) from _____ through _____.

I will take leave without pay from _____ through _____.

You may be required to show evidence of birth or placement for adoption or foster care. Family and Medical Leave may be used only in the first twelve months after birth or placement. After the twelve-month period, any leave requested will be in accordance with policies for leave of absence without pay for personal reasons.

If leave is requested for the employee's serious medical condition or for care of child, spouse, domestic partner, domestic partner's child, sibling, or parent with serious medical condition, certification from a health care provider is required and should be attached to this request. The certification should be provided prior to the start of the leave or within 15 days or the leave request, whichever is later. If proper certification is not provided, the leave request may be denied or delayed.

Group health and dental coverage will continue on the terms of active employment for up to a total of 12 weeks of federal FMLA leave, including paid and unpaid leave. Group health and dental coverage will continue on the terms of active employment for up to 26 weeks of FMLA leave for military caregiver leave.

At the end of a Family and Medical Leave, I understand that I may return to the job I held prior to the leave or an equivalent job. If the total leave exceeds 12 weeks (or 26 weeks for military caregiver leave) and becomes a leave without pay for personal reasons, return rights shall be in accordance with policies for leave without pay for personal reasons.

If leave is requested in the form of intermittent leave or reduced hours, it is my responsibility to schedule leave so as to not unduly disrupt school district operations, to the extent that is medically feasible. If leave is in the form of intermittent leave or reduced hours, I understand that I may be reassigned to an equivalent job for the period of the leave, if the position to which I am reassigned can better accommodate the leave.

Employee's signature:

_____ Date _____

Comments:

Building Principal's signature:

_____ Date _____