

FAMILY MEDICAL LEAVE APPLICATION
(LEAVE WITHOUT PAY)
Maximum: Twelve Weeks

NAME: _____ SOC. SECURITY # ____/____/____

ADDRESS: _____ PHONE _____

City

State

Zip Code

LOCATION (School): _____ POSITION: _____

IF TEACHER, grade and/or SUBJECT: _____

REASON FOR LEAVE: _____

LAST DAY YOU WILL WORK: _____

EFFECTIVE DATE OF FAMILY LEAVE: _____

DATE YOU WILL RETURN TO WORK: _____

SIGNATURE OF EMPLOYEE: _____

DATE REQUESTED: _____

Jacklene Jones, Director of Human Resources (signature)

DATE REVIEWED: _____

A PHYSICIAN'S STATEMENT MUST BE ATTACHED TO MEDICAL LEAVES. A RETURN TO WORK RELEASE MUST BE OBTAINED FROM PERSONNEL OFFICE PRIOR TO RETURNING TO WORK AFTER DOCTOR HAS OFFICIALLY GIVEN YOU A WRITTEN RELEASE

