School District of River Falls

REQUEST FOR FAMILY OR MEDICAL LEAVE

A request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin. If you have any questions as you complete this form, call the Bookkeeper at 425-1800 ext. 1112.

PLEASE PRINT

Name _____ **Date**_____/_____/_____

Department _____**Title**_____

Status: ☐ Full-time ☐ Part-time

I request a family or medical leave for one or more of the following reasons:

☐ Because of the birth of my child and in order to care for him or her.

Expected date of birth _____/_____/_____ Actual date of birth _____/_____/_____

Leave to start _____/_____/_____ Expected return date _____/_____/_____

☐ Because of the placement of a child with me for adoption or foster care.

Date of expected placement _____/_____/_____

Leave to start _____/_____/_____ Expected return date _____/_____/_____

☐ In order to care for my spouse, child or parent, who has a serious health condition.

Leave to start _____/_____/_____ Expected return date _____/_____/_____

☐ For a serious health condition that makes me unable to perform my job.

Describe _____

_____

Leave to start _____/_____/_____ Expected return date _____/_____/_____

☐ For other reasons. Describe _____

_____

Leave to start _____/_____/_____ Expected return date _____/_____/_____

☐ Requested intermittent leave schedule (if applicable, subject to employer's approval).

Describe _____

_____

Have you taken a family or medical leave in the past 12 months? ☐ Yes ☐ No

If yes, how many work days? _____ (over)

I understand and agree to the following provisions:

1. I have worked for the District at least one year and at least 1,000 hours in the previous 12 months.
2. I am aware that a physician's certification may be required for a leave due to a serious health condition.
3. If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to medical leave or other circumstances beyond my control, and if the District requires it, I will be financially responsible for the medical insurance premiums the District paid while I was on leave.
4. This leave will be unpaid, unless it is District policy to be paid; or in the case of my own disability, payment will occur under a District disability insurance plan, if I am so covered.
5. I may be required to exhaust my paid vacation, personal or sick leave as part of my 12 weeks of leave.
6. After 12 weeks of leave, if I do not return to work or contact my supervisor on the date intended, it will be considered that I abandoned my job.

Employee Signature_____ Date _____/_____/_____

Forward completed and signed request to your building administrator

Building Administrator Signature_____ Date _____/_____/_____

Director of Personnel Signature _____ Date _____/_____/_____

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Pink—Staff Member *Green—Building Administrator*