Onondaga Central School District

Committed to Excellence

Family and 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)
- ❑ Family Leave for qualifying exigencies arising out of the fact that my spouse, son, daughter or parent is on active duty or called to active duty status as a member of the Armed Forces, National Guard or Reserves in support of a contingency operation
- ❑ Military caregiver leave to care for my spouse, son, daughter, parent or next of kin of certain veterans with a serious injury or illness*
- ❑ 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 District Office.

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

_____ _____

Date Leave to Start Date Leave is to End

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.)*

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I have been provided a copy of Onondaga Central School District Board Policy #6551 and/or applicable provision of my collective bargaining agreement governing FMLA Leave. I understand that any previous FMLA leave occurring within the past 12 months will be subtracted from my total 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