Max Perez
Superintendent

Yvonne Tabet
Human Resources Director

FMLA LEAVE REQUEST FORM

- **Initial Application**
- **Extension Application**

(The following request is to be completed and returned to the Human Resources Office)

EMPLOYEE

Employee's Name: _____

Employee's Department: _____

Date: _____

I can be reached at the following address and phone number during my leave:

_____

Request for Full-Time Leave

I request a leave of absence from _____ (date) to _____ (date)
For the following reason:

- For the birth of my child and/or to care for the newborn child.
- For placement of a child with me for adoption or foster care.
- To care for my (circle one): spouse, child or parent with a serious health condition.
  Name: _____
- My own serious health condition.
- For another reason. (Please specify):

  _____

  _____

  _____

Request for Intermittent or Reduced-Schedule Leave

- I request intermittent leave or reduced-schedule leave at the following times:
  Schedule: _____
  Reason: _____

Substitution of Paid Leave

- I request to use (check all that apply):
- Paid Vacation
- Sick Hours
- Other

I understand that I am required to complete a FMLA Leave Certification of Health Care Provider form and submit the form to Human Resources before my leave commences. I understand that if my leave is approved, my time away from work will be charged against my 12 week leave maximum under FMLA. Upon approval of this requested leave, I am required to utilize all paid time available to me prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must contact Human Resources to make arrangements to pay my portion of health insurance premiums.

I request the following forms for my FMLA leave of absence:

1. **Certification of Health Care Provider:** A letter / note from my the physician stating the amount of time needed off for my own serious health condition and for whom the request is being made for.(if this leave is for my own serious health condition) or by my family member's health care provider (if this leave is for the serious health condition of a spouse, parent, or child).
   Failure to complete this form may delay or prevent my leave approval.
2. **Continuation of Benefits While on FMLA Leave:** This is an agreement between my employer and myself to continue my benefits while on FMLA leave and a financial arrangement for my portion of health care premiums.
3. **Notification of FMLA Status (Approval / Denial):** This is to notify me that my employer is designating the leave as FMLA leave and to inform me in writing of the specific expectations and obligations required by my employer under FMLA
4. **Request to Return from FMLA Leave:** Please fill out the top portion of the form, notifying Human Resources of the date that leave starts and ends. For my own serious health condition, a letter from my physician is required to return to work with no restrictions and returned to Human Resources prior to returning to work from FMLA leave.

I understand that the Certification of Health Care Provider form should be returned to Human Resources within 15 days. If I am not able to return the form within the allowed timeframe, I will contact Human resources for assistance 505-966-1030.

If this information is not received in the required timeframe, my leave will be considered unauthorized.

_____ _____

Employee Signature ***Approved By*** ***Date***

Hire Date: _____
Prior FMLA approvals within the past 12 months. _____

- o **Qualify**
- o **Does not Qualify**