



EMPLOYEE REQUEST FOR LEAVE APPLICATION

Check appropriate type:

- Family Medical Leave (FML)** – Employee is eligible if employed by FBISD for at least one year and worked at least 1250 hours during the previous year.
- Assault Leave (FML)** – An employee who is physically assaulted at work and sustained an injury as a result, may apply for assault leave. Eligibility is determined after an investigation.
- Temporary Disability Leave (TDL)** – A full time educator is eligible for reasons of own personal serious health condition. Employee shall be returned to active duty, subject to the availability of an appropriate position, no later than the beginning of the next school year.
- Unpaid Personal Leave (UPL)** – Employee may apply for unpaid leave for up to sixty calendar days in extenuating circumstances. The employee will indicate the beginning and ending date of the requested leave and must include all pertinent and supporting evidence needed to review for approval.

(Type or Print)

1. Name of employee (First name, Middle Initial, Last Name)		2. Employee's position	
3. Employee ID Number	4. Work Site	5. Grade/Subject/Position	
6. Reason for requested leave: a. <input type="checkbox"/> Birth of a son or daughter of the employee and in order to care for such son or daughter. (Does not apply to TDL) b. <input type="checkbox"/> Placement of a son or daughter with employee for adoption or foster care. (Does not apply to TDL) c. <input type="checkbox"/> In order to care for spouse, child, or parent with a serious health condition. (Does not apply to TDL) d. <input type="checkbox"/> Because of employee's own serious health condition that makes him/her unable to perform job function. e. <input type="checkbox"/> Unpaid Personal Leave – Must submit letter stating reason for request.			
7. If "c", please check one: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent		8. If "c", state name and attach doctor's confirmation of relative's medical condition.	
9. Date on which leave begins:		10. Date of anticipated return to work:	
11. Are you requesting leave on an intermittent or reduced leave schedule? (Applies only if eligible for FML) <input type="radio"/> Yes <input type="radio"/> No		12. If "yes", please give schedule of when you anticipate you will be unavailable for work. (Applies only if eligible for FML)	
Employees seeking leave because of reason "6 (c)" or "6 (d)" above must provide medical certification within 15 days or as soon as practicable. Employees seeking to return to work after a leave because of their own serious illness reason "6 (d)", also must provide the Human Resources Dept. a medical certification of ability to perform essential job functions before they are authorized by the Human Resources Dept. to return to work.			
I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date my leave expired or if I am needed to care for my spouse/parent/child because he/has has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the District until I provide medical certification, including a release to return to work. <p style="text-align: center;">THE MEDICAL CERTIFICATION FORM (DEC-E-3) MUST ACCOMPANY THIS FORM.</p>			
Employee's Signature _____		Principal/Supervisor's Signature _____	
Date _____		Date _____	
APPROVAL SIGNATURE:			
Human Resources Administrator Signature _____		Date _____	