

**Valley View I.S.D**  
**OFFICE OF HUMAN RESOURCES**

**FAMILY/MEDICAL LEAVE**  
**EMPLOYEE REQUEST FOR LEAVE FORM**

Type or Print

1. **Name of Employee:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Date of Employment with Valley View I.S.D:**

(Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous months, and if there are at least 50 employees within 75 miles)

2. **Employee's position:** \_\_\_\_\_ **Campus:** \_\_\_\_\_

3. **Reason for requested leave.**

- a.  Birth of son or daughter of the employee and leave to care for such son or daughter
- b.  Placement of a son or daughter with employee for adoption or foster care
- c.  To care for spouse, child, or parent with a serious health condition
- d.  Because of employee's own serious health condition that makes him/her unable to perform job functions

4. If "c", please check one:  Spouse       Child       Parent

5. If "c", state name and address of relation  
\_\_\_\_\_

6. Date on which you wish leave to commence. \_\_\_\_\_

7. Date of anticipated return to work. \_\_\_\_\_

8. Are you requesting leave on a full-time or intermittent basis?  Full-time     Intermittent

9. If intermittent, please give schedule of when you anticipate you will be available for work.  
\_\_\_\_\_

.....  
Employees seeking leave because of reason 3(c) or 3(d) above must provide medical certification. (Please attach to form)

Employees seeking to return to work after a leave because of their own serious illness {reason 3(d)} also must provide medical certification of ability to perform job duties before they are allowed to resume work  
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I hereby agree that while I am on leave, I will continue to pay any portion of my health premiums, which I normally am responsible for paying such as family, children, dental, cancer or high plan program etc 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 understand that I may not be permitted to resume my position with the District until I provide medical certification, as appropriate.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

**PLEASE FORWARD TO:**

Adela Troncosol Human Resource Office (Please attach medical certification and insure your Principal/Department Head's approval)  
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Principal/Department Head:	Approved _____	Not Approved _____	Signature/Date _____
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Superintendent/Designee:	_____	_____	_____
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# Your Rights

Under The

# Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250

hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

## Reasons For Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

## Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

## Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."



U.S. Department of Labor  
Employment Standards Administration  
Wage and Hour Division  
Washington, D.C. 20210

- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

## Unlawful Acts By Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA;
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

## Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

## For Additional Information:

If you have access to the Internet visit our FMLA website: <http://www.dol.gov/esa/whd/fmla>. To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm **in your time zone**; or log onto our Home Page at <http://www.wagehour.dol.gov>

