Glenbard Township High School District 87

Administration Center ▲ 596 Crescent Boulevard ▲ Glen Ellyn, Illinois 60137-4297 ▲ Phone: (630) 469-9100 ▲ Fax: (630) 469-9107

Family and Medical Leave Request Form

Eligible employees may use unpaid family and medical leave, guaranteed by the federal Family and Medical Leave Act ("FMLA"), for up to a combined total of twelve (12) weeks each 12-month period, which 12-month period shall be measured forward from the date any employee's first FMLA leave begins.

During a single 12-month period, an eligible employee's FMLA leave entitlement may be extended to a total of 26 weeks of unpaid leave to care for a covered service member (defined in the federal rules) with a serious injury or illness. The "single 12-month period" is measured forward from the date the employee's first FMLA leave to care for the covered service member begins.

Paid sick leave will be substituted for unpaid FMLA as long as a physician certifies the patient's illness or the serious health condition of an immediate family member and you have sick days available. A parent may substitute 30 days of sick leave for unpaid FMLA without a physician certification for the birth or adoption of a child as long as you have sick days available. The 30 days will begin on the first sick day used following the birth or adoption. The further use of sick leave will require a physician certification. FMLA leave runs concurrently with any available sick leave.

Your insurance benefits will continue during your leave under the same conditions as if you continued to work provided you continue to make your contributions towards coverage.

NOTICE: When possible, employees must provide at least 30 days's notice to the District of the date when a leave is to begin. If 30 days' notice is not practicable, the notice must be given within 2 business days of when the need becomes known to the employee. Employees shall provide at least verbal notice sufficient to make the District aware that he or she needs family and medical leave, and the anticipated timing and duration of the leave. Failure to give the required notice may result in a delay in granting the requested leave until at least 30 days after the date the employee provides notice.

EMPLOYEE		HOME PHONE
HOME ADDRESS		CITY, STATE, ZIP
SCHOOL	POSITION	HOME EMAIL

ELIGIBILITY:

1. Have you worked for Glenbard District 87 for one full year employed at least 1250 hours of service during the 12-month period immediately before the beginning of the leave? ☐ Yes ☐ No
2. Are you a full-time classroom teacher? ☐ Yes ☐ No
3. Have you previously received medical or family leave? ☐ Yes ☐ No

   If "yes," provide information below:

   Dates of previous leave:

   From_________________________________ to _________________________________ .

   Purpose of leave: ____

Name:_______________________________________

REASONS FOR REQUESTING LEAVE: Leave is available for any of the following reasons. Please indicate your reason for requesting Family and Medical Leave by checking the appropriate box(es).

- ☐ 1. The birth and first-year care of a son or daughter
- ☐ 2. The adoption or foster placement of a child
- ☐ 3. The serious health condition of an employee's spouse, parent, or child (physician's certification of disability required)
- ☐ 4. The employee's own serious health condition including pregnancy; (physician's certification of disability required)
- ☐ 5. The existence of a qualifying exigency arising out of the fact that the employee's spouse, child, or parent is a military member on covered active duty (or has been notified of an impending call or order to active duty) as provided in federal rules.
- ☐ 6. To care for the employee's spouse, child, parent, or next of kin who is a covered service member with a serious injury or illness as provided by federal rules.

If spouses are employed by the District, they may together take only 12-weeks for FMLA leaves when the reason for the leave is 1 or 2 above, or to care for a parent with a serious health condition, or a combined total of 26 weeks for item 6 above.

DATES OF LEAVE REQUESTED:

I request leave from ________________________ to ________________________.

Classroom teachers may be required to wait to return to work until the next semester in certain situations as provided by law and stated in the special rules concerning instructional personnel.

The total number of days of leave that I request is __________________.

Any days that the employee would not have been required to work, including summer, winter and spring break, are not counted against the FMLA leave entitlement.

If intermittent leave is requested, estimate the part-time or reduced work schedule.

__________hour(s) per day; __________ days per week from_____________ through _____________

The total number of hours of leave that I request is __________________.

You are required to notify the Human Resource Office as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown.

EMPLOYEE STATEMENT:

I agree to return to work on _______________________________.

A physician's return to work authorization will be required if the FMLA leave was due to the employee's own serious health condition, including pregnancy disability.

If circumstances change such that I will not be able to return to work on that date, I agree to inform the Human Resource Coordinator in writing 15 days prior to the end of my leave of the need to change my approved medical or family leave. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Signature:____Date:________________

Revised 4/2015