Mecosta-Osceola Intermediate School District
15760 190TH Avenue, Big Rapids, MI 49307 | 231.796.3543

Family and Medical Leave (FMLA) Request Form

Employee Name: _____ Title: _____

Supervisor: _____ Department: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) for up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. **Submit this request form to your Supervisor or Human Resources at least 30 days before the leave is to commence, when practicable.** The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

DATE(S) OF LEAVE REQUESTED: _____ to _____

TYPE OF LEAVE REQUESTED:

☐ Full-Time Leave ☐ Intermittent or Reduced Schedule, Explain: _____

_____

REASON FOR REQUESTED LEAVE (Please check the appropriate box):

☐ The birth of a child, or placement of a child with me for adoption or foster care, and to bond with the newborn or newly-placed child. Date of birth/placement: _____

☐ My own serious health condition (additional information required).

☐ To care for spouse, child (under 18 or 18 or older with disability and incapable of self-care) or parent with serious health condition. Name of and relationship to family member: _____

☐ qualifying exigency for family member on active duty: ☐ Spouse ☐ Parent ☐ Child

☐ To care for family servicemember with serious injury or illness:
☐ Spouse ☐ Parent ☐ Child ☐ Next of kin

EMPLOYEE STATEMENT:

I agree to return to work on _____, barring extreme and unforeseen circumstances. If circumstances change such that I will not be able to return to work on that date, I agree to contact Human Resources and/or my Supervisor. I understand that my benefits will continue during my FMLA leave and that I will arrange to pay my share of applicable premiums. I understand that I will be required to use all available leave time while on FMLA and that I will not be paid during FMLA leave once my accumulated leave has been depleted.

Following a leave because of my own serious illness, I understand that I must have my physician authorize in writing, my ability to return with or without any restrictions that could substantially limit my ability to perform my job duties. I agree to provide that documentation to Human Resources prior to my return.

Signature: _____ Date: _____

Submit completed form to Dana Boglarsky, Benefits Specialist

For Internal Use Only

☐ Approved ☐ Denied

_____ _____

Dana Boglarsky
Benefits Specialist
dboglarsky@moisd.org
796.3543 ext. 1322

Date

cc: Business Office