FAMILY AND MEDICAL LEAVE REQUEST FORM DUE 30 DAYS BEFORE LEAVE BEGINS RICHMOND COUNTY SCHOOL SYSTEM

DIRECTIONS: Employees of the Richmond County Board of Education **MUST** complete this request form and submit to the Human Resources Department at least 30 days before the anticipated date of family and medical leave, except in cases of emergency. In emergencies, the employee must submit all required documents no later than five (5) days from the first day of leave. The supporting documentation as described below is ESSENTIAL before requests for leave will be approved and granted. Check the appropriate category of leave, complete the required information in the spaces provided and attach all required documentation.

NAME: _____ **SS#:**_____

SCHOOL/DEPARTMENT: _____**POSITION:**_____

DATE FORM COMPLETED: _____ **DATE EMPLOYEE BY SYSTEM:** _____

SIGNATURE OF EMPLOYEE REQUESTING LEAVE: _____

Is spouse employee by the Richmond County Board of Education? Yes _____ **No** _____

If yes, name of spouse: _____

☐ **Birth of Child**

Date Leave anticipated to begin: _____ **Expected date of return to work:** _____

REQUIRED DOCUMENTATION: Doctor's statement verifying the anticipated leave date and anticipated expected date of return to work.

☐ **Placement of a child for adoption,** ☐ **Foster care or care for the newly placed child**

Date of leave requested will begin: _____

Expected date of return to work: _____

REQUIRED DOCUMENTATION: If adoption, copy of adoption papers, if foster child or newly placed child copy of foster care placement records.

☐ **Serious Health Condition of Employee described under FMLA**

Date of leave requested will begin: _____ **Expected date of return to work:** _____

Requesting Intermittent Leave? _____ **Yes** _____ **No If yes, describe:** _____

REQUIRED DOCUMENTATION: "Certification of Physician or Practitioner" form must be completed in entirety by physician or health care provider.

☐ **Serious Health Condition of Family Member as described under FMLA**

Date of leave requested will begin: _____ **Expected date of return to work:** _____

Requesting Intermittent Leave? _____ **Yes** _____ **No If yes, describe:** _____

REQUIRED DOCUMENTATION: "Certification of Physician or Practitioner" form must be completed in entirety by physician or health care provider.

ACKNOWLEDGEMENT BY PRINCIPAL OR SUPERVISOR: _____ **Date:** _____

HUMAN RESOURCES DEPARTMENT USE ONLY **Date Received:** _____

Leave Designated as FMLA: _____ **Yes** _____ **No**

cc: School/Department **cc: Payroll** **cc: Human Resources Department** **cc: Employee**