Cartersville City Schools
Human Resources

Family Medical Leave Request Form

Employee Name: _____ Employee #: _____

Employee Title: _____ School/Location: _____

Employee Street Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Eligible employees are entitled under the Family & Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. A request for FMLA should be submitted to the employee's principal/supervisor at least 30 days before leave is to begin, when practicable. When submission of the request 30 days in advance is not feasible, submit the request as early as possible but no later than 3 days from commencement of a qualifying event. 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.

I. ELIGIBILITY

☐ YES ☐ NO

Have you worked for this school district for a total of 12 months or more (whether they were consecutive or not)? If no, you are not eligible for FMLA. If yes, proceed to next question.

☐ YES ☐ NO

During the past 12 months, have you worked for this school district at least 1,250 hours (approximately 8 months of 40-hour weeks or one year of 25-hour weeks)? If no, you may not be eligible for FMLA. If yes, proceed to next question.

☐ YES ☐ NO

Have you taken any intermittent leave (on/off again FMLA) or reduced (partial days/weeks) FMLA in the last 12 months?

II. DATES REQUESTED

FROM: _____ TO: _____

Beginning Date *Ending Date*

☐ Check here if you are requesting an extension of a previously approved FMLA leave.

III. REASON FOR REQUESTED LEAVE

☐ Personal Serious Health Condition/Disability

☐ Serious health condition of an eligible immediate family member (spouse, child, parent, spouse's parent)
Name: _____

☐ Birth of a child Expected Delivery Date is: _____

☐ Adoption or placement of a child for foster care. (Name of Child: _____)
Schedule Date of Adoption or Placement: _____

☐ Qualifying exigencies arising out of eligible family member on active duty or call to active duty status as a member of the National Guard of the National Guard or Reserves in support of a contingency operation.

☐ E-FMLA (COVID-19) Explain: _____

IV. Employee Statement

I plan & agree to return to work on _____. If circumstances change such that I will not be able to return on that date, I agree to inform my supervisor and the Payroll Department by submitting written notice. I understand that my benefits will continue during my leave and that I will arrange to pay my share of all applicable premiums. Additionally, I have received a copy of the Board Policy regarding FMLA.

_____ _____
Employee Signature Date

☐ Approved ☐ Denied _____ _____
Principal/Supervisor Signature Date

☐ Eligible ☐ Ineligible _____ _____
Payroll Department Signature Date

☐ Approved ☐ Denied _____ _____
Human Resources Signature Date

Updated 9/10/21