The School Board of St. Lucie County, Florida

APPLICATION FOR FAMILY AND MEDICAL LEAVE ACT (FMLA)

Employee Name: _____

Employee Job Title: _____ Employee Work Location: _____

Employee's Supervisor: _____

INSTRUCTIONS TO EMPLOYEE: The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition or to care for a covered family member with a serious health condition. If requested, your response is required to obtain or retain the benefit of FMLA protections, pursuant to 29 U.S.C. §§ 2613, 2614(c)(3). If this leave is for a serious medical condition of yourself or a covered member of your immediate family, you must have the physician who is treating the individual complete the Medical Certification Statement form. **Failure to provide a complete and sufficient medical certification may result in the denial of your FMLA request,** pursuant to 29 U.S.C. § 825.313. You have at least fifteen (15) calendar days to return the Medical Certification Statement form to your employer, pursuant to 29 U.S.C. § 825.305, if it is not attached to this application.

Family Medical Leave may be granted for up to sixty (60) working days for maternity leave, paternity leave, adoption of a child or for the serious medical condition of yourself or a covered member of your immediate family for whom you are needed to be the primary care-giver. **This leave is not given in addition to use of accumulated sick and/or vacation leave, use of sick bank leave, or worker's compensation leave** but runs concurrently with your accumulated sick and/or vacation leave which begins on the first day of absence for any of the qualified reasons.

Eligibility requirements:

To be an eligible employee you must **1)** be employed continuously by the district for at least twelve (12) months **2)** work a minimum of 1250 hours during the last twelve (12) months **3)** have a serious medical condition

This Family and Medical Leave of Absence is for the following qualifying reason:

_____ The birth of a child or placement of a child with you for adoption or foster care.
_____ Your own serious health condition.
_____ Because you are needed to care for your ( ) spouse ( ) child ( ) parent due to a serious health condition.
_____ Because of a qualifying exigency arising out of the fact that your ( ) spouse ( ) son or daughter ( ) parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
_____ Because you are the ( ) spouse ( ) son or daughter ( ) parent ( ) next of kin of a covered service member with a serious injury or illness (up to 26 weeks).

Please describe the care you will require or provide to your immediate family member and estimate the leave needed.

_____

_____

_____

_____

Anticipated date FMLA is to begin _____ date FMLA is to end _____

_____ _____
Employee's signature Date