Application for Family or Medical Leave

Name: _____ Teams ID: _____

Campus: _____ Assignment: _____

Current Address: _____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

Reason for Leave (Explain): _____

_____

Work Related? Yes ____ No ____

If leave is for illness or death of immediate family member, state relationship: _____

Note: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification physician within 15 days of application for leave.

I authorize a representative of Carrollton-Farmers Branch ISD to contact my health-care provider to verify the authenticity of the medical certification for my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as absent without leave, and may result in further disciplinary action up to and including termination of employment, unless additional leave, pursuant to Board Policies DEC(Legal) and DEC(Local) has been agreed upon and approved in writing.

Type of leave Requested:

FMLA: _____ Sick Leave Bank: _____ Extended Sick Leave: _____ Work Comp _____

Signature: _____ Date: _____

I prefer communication be submitted to me via ☐U.S. Mail or ☐district e-mail.

Received by:

Supervisor/Principal: _____ Date: _____

Payroll Department: _____ Date: _____

Approved by Sick Leave Bank Committee: Yes _____ No _____

Payroll Director: _____ Date: _____