

Application for Family or Medical Leave

Name:			_ Teams ID:
Campus:		Assignment:	
Current Addres	SS:		
Start Date of A	nticipated Leave:	Expected Date of R	eturn to Work:
Reason for Lea	ve (Explain):		
Work Related?	Yes No		
If leave is for il	lness or death of immediate family n	nember, 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.		
	without leave, and may result in fu	rther disciplinary action up ve, pursuant to Board Polic	leave period may be treated as absent to and including termination of ies DEC(Legal) and DEC(Local) has been
Type of leave I	Requested:		
FMLA:	Sick Leave Bank:	Extended Sick Leave:	Work Comp
Signature:			Date:
l prefer commi	unication be submitted to me via \Box \Box	J.S. Mail or □district e-ma	il.
Received by:			
Supervisor/Principal:			Date:
Payroll Department:			Date:
Approved by S	ick Leave Bank Committee: Yes	No	
Payroll Director:			Date: