Family and Medical Leave Request

LEAVE APPLICATION FOR BONDING

Employer: Mat-Su Borough School District

Contact: Payroll Department Phone: 907-761-4095 Fax: 907-761-4088

SECTION I: FOR COMPLETION BY THE EMPLOYEE

Instructions to the Employee: Please complete Section I before giving this form to your medical provider. 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. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825-305(b).

Employee Name:

____________________ _______________ ___________________

First Middle Last

Employee Job Title: ____

Regular Work Schedule: ____

Select which situation describes the purpose of your leave request.

☐ Care of my new-born child ☐ Placement of a child for adoption ☐ Placement of a child for foster care

____

Child's name

In order to verify that our relationship entitles me to FMLA leave to care for this individual, I have attached a copy of the following:

☐ Birth certificate

☐ Court document: ____

OR

☐ I certify that the family member for whom I need to provide care for under the FMLA/AFLA is a covered family member as noted above in the purpose of my leave request.

***Section II should only be completed if an expectant mother is requesting time off before the birth of a child. Please bring the MSBSD Job Description for your position to your health care provider for evaluation during your appointment.*

SECTION II: FOR COMPLETION BY THE HEALTH CARE PROVIDER

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

Health Care Provider's name: ____

Type of practice/ Medical Specialty: ____

Business Address: ____

Telephone: ( ) ________________ Fax: ( ) ________________

PART A: MEDICAL FACTS

1. Is the medical condition pregnancy? ☐ Yes ☐ No. If so, expected delivery date: _______

2. Use the information provided by the employee in their job description from their employer to answer this question. If no job description is available, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee able to perform all of her job functions due to the condition?

   ☐ Yes ☐ No

   If not, identify the job functions the employee is unable to perform:

   ____

   ____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   ____

   ____

   ____

   ____

PART B: AMOUNT OF LEAVE NEEDED

4. Will the employee be incapacitated for a single continuous period of time due to her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   If so, estimate the beginning and ending dates for the period of incapacity: ______________

5. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   ____

   Estimate the hours the patient needs care on an intermittent basis, if any:

   ______ hour(s) per day; ______ days per week from __________ through________

ADDITIONAL INFORMATION:

____

____

____

____
Name of Health Care Provider (printed)

____ __________________
Signature of Health Care Provider Date

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SECTION III: EMPLOYEE COMPLETION DIRECTIONS AND SUPERVISOR APPROVAL

In accordance with federal and state mandated law, the Matanuska-Susitna Borough School District has instituted the ability for eligible employee's to request and take Family and Medical Leave. All documentation related to the employee's medical condition will be kept confidential and maintained in the employee's medical records file. The District may require additional information in order to process this request. If you have questions, contact Payroll.

Employee - Please bring completed form to the Payroll Department: After all information is filled out by you (employee), the physician (with signature), and this page (page 4) is signed by your supervisor/principal, bring this packet to Payroll for approval of leave request.

EMPLOYEE NAME: ______________________________ **EMPLOYEE ID:** ____________

Reason for Family/Medical Leave Request: BONDING

1. Begin and End Dates of Leave Request: Must be completed in order for request to be considered. (the employee shall have the responsibility to notify their Supervisor and the Payroll Department in the event any dates needed for Family Leave change.)

Begin Date: ____________________ End Date: ______________________

2. An intermittent or Reduced Leave Schedule may be requested for the serious illness of the employee or immediate family member, if medically necessary.

3. Employees must utilize all of their paid leave prior to leave without pay. Please indicate the categories of leave you plan to use while on Family and Medical Leave.

_____ Sick Leave _____ Floating Holidays _____ Leave Without Pay

_____ Personal Days _____ Sick Leave Bank

Address while on leave: ___________________________
____
____

Phone number on leave: ___________________________

___________________________ ______________

Employee Signature Date

___________________________ ______________

Principal/Supervisor Signature Date

Supervisory signature indicates knowledge of request. Official approval of request will come from the Payroll Department.