CORTLAND ENLARGED CITY SCHOOL DISTRICT

Request for Family and/or Medical Leave - FMLA

DIRECTIONS TO EMPLOYEE:

Please fill out all sections on the front side of this form and return it to your building Principal / Supervisor at least 30 days prior to your anticipated leave date, or if your leave is unforeseeable, as soon as practicable. **In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave. School year July-June is used in calculating eligibility.**

REQUESTED INFORMATION FOR LEAVE:

Employee Name: _____ Today's Date: _____/_____/_____

Are you requesting partial or intermittent leave? ☐ Yes ☐ No If yes, describe frequency: _____

Requested Leave dates: Leave to begin: _____/_____/_____ End date: _____/_____/_____

Requested use of days: _____ Sick ____ Family Sick ____ Personal ____ Unpaid

REASON FOR LEAVE: Check appropriate box(es).

☐ **PARENTAL LEAVE:** Leave to care for newborn or newly adopted child or foster-placed child; or the placement with me of a child for adoption or foster care.

☐ **MEDICAL LEAVE:** Leave due to a serious health condition that makes one unable to perform at least one of the essential functions of position. Diagnosis: _____ (required)

☐ **FAMILY LEAVE:** Leave to care for a family member with a serious health condition.
Diagnosis: _____ (required)

☐ **QUALIFYING EXIGENCY LEAVE:** Leave relating to an immediate family member (spouse, child, parent) that is called to active duty in the National Guard or Reserves; or relating to care for a family member who incurred a serious injury or illness in the line of active duty in the Armed Forces. Circle one: Spouse Child Parent

CERTIFICATION REQUIREMENTS: I understand that for leave for my own serious health condition or to care for that of a family member, I am required to submit a Certification Form (ie. Medical Statement), fully completed by a qualifying health care provider, **within 15 days**, and that my failure to do so may result in denial of leave and/or disciplinary action, up to and including termination or employment for unauthorized absence. I also understand that I must provide documentation for other leaves.

CERTIFICATION DUE BY: _____/_____/_____ (15 calendar days from date of request)

ACKNOWLEDGEMENT: I hereby certify that the above information is true to the best of my knowledge, understanding and belief. I understand that if any of the above information is false, I am subject to discipline, up to and including termination of employment. I also understand that it is my responsibility to immediately contact the Superintendent of Schools if I am unsure of my obligations with regard to my leave and/or the circumstances resulting in my leave entitlement change.

EMPLOYEE SIGNATURE: _____ DATE: _____

SUPERVISOR/PRINCIPAL SIGNATURE: _____ DATE: _____

DISTRICT OFFICE SIGNATURE: _____ DATE: _____

SUBMIT THIS FORM TO YOUR SUPERVISOR TO REVIEW AND SUBMIT TO THE PERSONNEL OFFICE

If you have any questions please contact the Payroll Coordinator at (607) 758-4122.

DISTRICT OFFICE USE ONLY

PERSONNEL OFFICE: Enter the information from the front side into the shared Google Sheet.

Check appropriate box(es).

Has the employee been employed by CECSD for 12 months? Yes ☐ No ☐

Has the employee worked for more than 1,250 hours in the past 12-month period? Yes ☐ No ☐

Has the employee taken any family/medical leave in the past 24 months? Yes ☐ No ☐

List all types of leave and dates within the past 24 months:

Leave Type: _____ Start date: _____/_____/_____ End date: _____/_____/_____ # Weeks: _____

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BUSINESS OFFICE: Complete the following:

	Available to Use	Approved to Use	Date Range for Use
Sick Days	_____	_____	_____
Family Sick Days	_____	_____	_____
Personal Days	_____	_____	_____
Unpaid Days		_____	_____

SUPERINTENDENT OFFICE: **District Response to Request for Leave under the Family Medical Leave Act**

_____ Your FMLA leave request is approved under the above conditions.

_____ Your FMLA Leave request is Not Approved. (Reason attached)

_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

_____ Additional information is needed to determine if your FMLA leave request can be approved.

_____ The certification you provided is not complete and sufficient to determine whether FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. _____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and will provide further details at a later time.

SUPERINTENDENT OR AUTHORIZED DESIGNEE SIGNATURE: _____

DATE: _____

Routing List for BOE Clerk below:
Original to Personnel
Copy to Payroll
Copy to Staff member