CORTLAND ENLARGED CITY SCHOOL DISTRICT

Request for Family and/or Medical Leave

Name: _____(Please Print) Location: _____

Directions – Please submit this form no less than 30 days prior to the anticipated beginning date of your leave, 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.**

☐ **PARENTAL LEAVE**

(Leave to care for newborn or newly adopted child or foster-placed child)

Reason for parental leave: ☐ Birth of a child ☐ Adoption of a child ☐ Placement of a foster child

Anticipated begin date: _____ Anticipated end date: _____

☐ **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: _____

Anticipated begin date: _____ Anticipated end date: _____

☐ **FAMILY LEAVE**

(Leave to care for a family member with serious health condition.)

Name of family member: _____ Relationship:_____

Diagnosis: _____

Anticipated begin date: _____ Anticipated end date: _____

DAYS REQUESTED

Paid days requested: _____ Unpaid days requested: _____ Total: _____

Indicate type of paid leave to be used:

_____ Number of Sick days _____ Number of Family days _____ Number of Personal days

QUALIFYING EXIGENCY LEAVE:

(Military Family Leave)

_____ Because of qualifying exigency arising out of the fact that your _____ spouse; _____ son or daughter; _____ parent is on active duty or call to active 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.

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, 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: _____/_____/_____.

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.

_____ _____

(Signature of Employee) (Date)

_____ _____

(Signature of Supervisor/Principal) (Date)

District Response to Request for Leave under the Family Medical Leave Act

_____ **Your FMLA leave request is approved.**

_____ **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 have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than_____, unless it is
(provide at least 7 calendar days)
not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied. _____
(Specify information needed to make the certification complete and sufficient)
_____

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

If you have any questions please contact Jen Storey, Payroll Coordinator at (607) 758-4100.

_____ _____
Superintendent Date

DISTRICT OFFICE USE ONLY

Has employee been employed by CECSD for 12 months?	☐ Yes	☐ No
Has employee worked more than 1,250 hours in the past 12-month period?	☐ Yes	☐ No
Has employee taken any family/medical leave in the past 24 months?	☐ Yes	☐ No

List all types of leave and dates:

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

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

Routing List for BOE Clerk below:

- ☐ Original to Personnel
- ☐ Copy to Payroll
- ☐ Copy to Staff member