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 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: ___/___/____
Leave Type: _____________________________ Start date: ___/___/____ End date: ___/___/____
Leave Type: _____________________________ Start date: ___/___/____ End date: ___/___/____

Routing List for BOE Clerk below:
☐ Original to Personnel  ☐ Copy to Payroll  ☐ Copy to Staff member  Revised 4-2016