



# 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 CECSO 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