THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
REQUEST FOR FAMILY LEAVE/MEDICAL LEAVE (FMLA)
Under the Family & Medical Leave Act
NON-INSTRUCTIONAL AND ADMINISTRATIVE, SUPERVISORY, PROFESSIONAL & TECHNICAL PERSONNEL

1. Employees
   a. **MUST SUBSTITUTE** any accrued paid vacation and personal reasons leave for **family leave**.
   b. **MUST SUBSTITUTE** any accrued paid vacation, personal reasons leave, sick leave, paid medical leave and Workers' Compensation leave for medical leave.
2. All requests for **medical leave** due to your illness or the illness of a covered family member must include a completed "Certificate of Health Care Provider" form.
3. All requests for **family leave** due to adoption or Foster Care must include official notification such as a letter from the appropriate agency or attorney.
4. Military Family Leave requests must include a copy of the family member's official military orders.
5. Family/Medical Leave (paid and/or unpaid) cannot exceed twelve (12) weeks.
6. If personnel numbers, dates and signatures are missing, the application cannot be processed and will be returned.

Name: _____ **Personnel Number:** _____

Address: _____ **Cellular Number:** _____

City/State/Zip: _____ **Other Telephone Number:** _____

School/Department Name: _____ **Position:** _____

REASON FOR LEAVE:
(Check One)

FAMILY LEAVE
- ☐ Maternity
- ☐ Adoption or Foster Care
- ☐ Military Family Leave (Serious injury or illness of a current service member)
- ☐ Military Qualifying Exigency

MEDICAL LEAVE
- ☐ Illness of Self
- ☐ Illness of Family Member
- ☐ Military Caregiver Leave (Serious injury or illness of a veteran)

THIS LEAVE REQUEST IS FOR THE FOLLOWING DAYS AND DATES:

NUMBER OF DAYS	DATES START	DATES END
_____ Paid Days Used	_____	_____
_____ Unpaid Days Used	_____	_____
_____ **Total Days**	_____	_____

Return to Work Date: _____
(Date should be the first workday following medical release date)

EXPLANATION: (Every request must contain a brief explanation) _____

_____

_____

I understand and agree that failure to return to work at the end of my leave period will be treated as a voluntary termination of employment. If additional time is needed, I understand I must apply for another type of leave.

Employee's Signature: _____ **Date:** _____

THE PRINCIPAL/DEPARTMENT HEAD'S SIGNATURE CONFIRMS:

- This applicant is provisionally placed on Family/Medical Leave pending review of the application, medical certificate and eligibility verification.

_____ _____
Principal/Department Head's Signature Date

Approved By: _____ **Date:** _____
Chief Financial Officer, The School Board of Broward County, FL.

ROUTING INSTRUCTIONS:
Work Location forwards application and medical certification (if received) to the Leaves Department. A copy of the application will be returned after processing.