

THE SCHOOL BOARD OF BROWARD COUNTY, FL
REQUEST FOR FAMILY MEDICAL LEAVE (FMLA)
Under the Family & Medical Leave Act
INSTRUCTIONAL PERSONNEL



1. All requests for **medical leave** due to your illness or the illness of a covered family member must include a completed "Certification of Health Care Provider" form.
2. 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.
3. Military Family leave requests must include a copy of the family member's official military orders.
4. The instructional employee taking **family leave** must take a minimum of 20 unpaid days.
5. Family/Medical Leave (unpaid days used) cannot exceed twelve (12) weeks.
6. If social security and personnel numbers, dates and signatures are missing, the application cannot be processed and **will be returned**.

Name: _____ Social Security Number: _____
Address: _____ Personnel Number: _____
City/State/Zip: _____ Daytime 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.)

LEAVE REQUEST IS FOR THE FOLLOWING DATES:

	NO. OF DAYS	START	<u>DATES</u>	END
	_____ Paid Days Used	_____	-	_____
	_____ Unpaid Days Used	_____	-	_____
	_____ TOTAL NO. OF DAYS	_____	-	_____

Return to Work Date: _____
(Date should be the first workday following the end of FMLA)

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 that 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: _____
Division of Human Resources, The School Board of Broward County, FL

ROUTING INSTRUCTIONS:

School/Location forwards application and medical certification to the Leaves Department. A copy of the application will be returned after approval.