

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

Please email documentation back to leaves@browardschools.com

EMPLOYEES:

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 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: _____

Personal Email: _____

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)

TYPE OF FMLA: (Check one)

CONTINUOUS FOR THE FOLLOWING DAYS AND DATES:

(Office Manager must confirm availability of number of Sick Days to be used)

Sick Days to be Used _____ - _____
Prior to the Start of FMLA
Unpaid Days Used _____ - _____

INTERMITTENT:

Start 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: _____

Director, Benefits & Employment Services or Designee

A copy of the application will be returned after processing.