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

Please email documentation back to leaves@browardschools.com

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: _____ **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 Paid Days Used)

Number of Days		Start Date		End Date
_____	Paid Days Used	_____	–	_____
_____	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.