



Dougherty County School System

REQUEST FOR FAMILY AND MEDICAL LEAVE (FMLA)

TO BE COMPLETED BY EMPLOYEE (Type or Print)

Form with fields: 1. Name, 2. Position and Location, 3. SS#, 4. Date of Request, 5. Reason for requested leave, 6. If 'C' please check one of the following, 7. If 'C' state name, address, and relationship, 8. Date on which your leave will begin, 9. Date of anticipated return to work, 10. Are you requesting leave on an intermittent or reduced leave schedule?, 11. If 'yes' give schedule of when you will be unavailable for work.

§ 825.100 The Family and Medical Leave Act of 1993 allows "eligible" employees of a covered employer to take a job-protected, unpaid leave, or to substitute appropriate paid leave for up to a total of 12 workweeks in any 12 months. §825.110 An "eligible employee" is an employee of a covered employer who has been employed by the employer for at least 12 months and 1250 hours of service during the 12-month period immediately preceding the commencement of the leave.

Employees seeking leave because of reason 5A, 5C or 5D above must complete a Medical Certification Form # WH-380 and return it to the DCSS Leave Office within 15 days or as soon as practicable. I understand that my leave may be delayed until I provide a completed Medical Certification Form.

Employees seeking to return to work after a leave because of their own serious health condition also must complete a Return to Work Medical Certification Form before they are allowed to resume work. I understand that I may not be permitted to resume my position until I provide a completed Return to Work Medical Certification Form.

I hereby agree that while I am on leave, I will continue to pay my health (and other) insurance premiums, unless I elect to discontinue such coverage. I am aware that insurance premiums more than 30 days past due could result in loss of coverage. I also agree that if I fail to return to work at the end of the leave period, I will be required to reimburse my employer for the cost of insurance premiums provided by them during my leave.

Supervisor Signature: X Date

(To indicate his/her awareness of your request for leave)

Employee Signature: X Date

All leave forms can be obtained from, and all completed leave forms should be forwarded to the Benefits Office as soon as possible. Please direct any leave questions to (Benefits Leave Clerk) at 229-431-1260.

Send completed form to the Benefits Leave Clerk as soon as possible. Must have supervisor's signature.