

EMPLOYEE APPLICATION FOR FMLA

(Family and Medical Leave Act)

Employee: _____

Home Phone: _____

Position Title: _____

Supervisor: _____

The Family and Medical Leave Act (FMLA) requires that covered employers provide up to 12 weeks of job-protected leave, to eligible employees for certain family and medical reasons, within a 12-month period. All qualifying leaves will be charged against the 12 weeks of annual FMLA leave. Eligible employees may continue in an employer-sponsored health insurance plan for up to 12 weeks during FMLA leave. For purposes of FMLA, a 12-month period is a fiscal (school calendar) year (July-June).

I AM REQUESTING FMLA LEAVE DUE TO: (complete **ONE** of the following - see serious health condition definitions enclosed)

_____ A serious health condition that makes me unable to perform the essential functions of my job

Describe Condition: _____

_____ A serious health condition for which I am needed to provide care for my _____ spouse, _____ parent, _____ child under age 18, or _____ child over age 18 and incapable of self-care.

Family Member Name: _____ **Date of Birth:** _____

Describe Condition: _____

_____ Birth of Child - **Due Date:** _____

Pregnancy disability leave covers **the period of disability designated by your physician** for the period preceding or following the birth of your child. Unpaid childcare leaves may also be granted under policies and contracts. Please refer to the appropriate collective bargaining agreement for additional information.

_____ Adoption or Foster Care - **Anticipated Date:** _____

_____ A qualifying exigency arising out of the fact that my _____ spouse; _____ son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

_____ I am the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered service member with a serious injury or illness.

DOCTOR: _____ **TYPE OF PRACTICE:** _____

ADDRESS: _____ **TELEPHONE:** _____

METHOD OF LEAVE _____ Consecutive _____ Intermittent leave (specify schedule) _____

FIRST DAY OF LEAVE: _____ **RETURN TO WORK DATE:** _____

Employees must use sick/personal time for disability period. All days (paid/unpaid) run concurrent with leave.

HEALTH INSURANCE (to ensure coverage during **unpaid days beyond FMLA leave**)

[] **YES**, I wish to continue my health insurance coverage during any unpaid days of my leave.
I understand that if my payments are not made on a timely basis, my insurance coverage will be terminated.

[] **NO**, I do not wish to continue my health insurance coverage during any unpaid days of my leave. Please cancel my coverage.
I understand it is my obligation to contact the Business Office when I wish to resume coverage.

EMPLOYEE SIGNATURE: _____ **Date:** _____

Complete and return this form to:
Olean High School c/o Amber Aderman
410 W. Sullivan St.
Olean, NY 14760