FAMILY MEDICAL LEAVE ACT (FMLA)
APPLICATION
CONCRETE SCHOOL DISTRICT NO. 11

An eligible employee is anyone who has been employed by the District for at least twelve (12) months and for at least 1,250 hours of service during the twelve (12) months immediately preceding the start of leave.

_____
Date Application Received
By District Office

_____ _____
Employee Name Application Date

_____ _____
Position of Employee Hours per Day

FMLA = 60 DAYS FMLA Days converted to Hours: _____

Specific Dates to Be Covered: _____

Total number of Leave Days to be taken: _____

Please indicate dates covered by FMLA within the immediate preceding twelve months

_____

ELIGIBILITY REQUIREMENTS (Check one only)

A. Birth of Child or Care for Newborn Child _____
B. Placement of a Child with Employee for Adoption or Foster Care _____
C. Care for Employee's Spouse, Parent or Child
(Under age of 18 or Age 18 or older and incapable of self-care
because of Mental or Physical Disability) with a Serious Health Condition _____
D. Employee's own Serious Health Condition that make the employee
unable to perform his or her job _____

If eligibility requirement (A) is indicated above, is spouse also an employee of the District and included with this request for FMLA

_____ YES _____ NO

If spouse is included in this request, please complete the following:

_____ _____ _____
Name of Spouse Position Hours per day

FMLA = 60 DAYS FMLA Days Converted to Hours _____

Specific Dates to be covered: _____

Please indicate dates spouse covered by FMLA within the immediate preceding twelve months_____

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PROCEDURES

1. Copy of District Policy provided to Applicant _____ Date Sent

2. Applicant to submit application for use of FMLA to Building Principal with a copy forwarded to the District Office _____ Date Received

3. Applicant to provide District Office with certification from Health Care Provider of the serious health condition within fifteen (15) calendar days of the Request for Leave (Failure to submit certification will invalidate request for leave under FMLA) _____ Date Received

4. The District will maintain Group Health Plan Benefits during this period covered by FMLA, paying the same portion of the premium as it did while the applicant was at work. The Applicant will be responsible for timely payment of his or her portion of the premium. Applicant portion of benefit coverage to be submitted to District Office no later than the 25th of each month. Failure of the applicant to do so will relieve the District of the employer's obligation to continue it's contribution for these benefits.

5. Should the employee fail to return from leave, the employee will be required to reimburse the district within 45 calendar days following the date in which the employee was scheduled to return to work for all district-paid premiums during the leave.

6. Employee will be required to substitute all accrued Sick Leave, Personal Leave, applicable Vacation Leave and applicable Family Leave for otherwise unpaid FMLA Leave.

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District Office Use Only

Date Certification from Health Care Provider Received _____

Available Sick Leave Hours As Of _____ _____

Applicable Available Vacation Leave Hours as Of _____ _____

Available Personal Leave Hours as of _____ _____

Applicable Available Family Leave Hours as of _____ _____

TOTAL LEAVE HOURS AVAILABLE _____

Available FMLA Hours _____

Total Paid Leave Available _____

Remaining Unpaid Days covered by FMLA _____

Number of Days not covered by above Leaves _____

FMLA Start Date _____

FMLA End Date _____

Anticipated Date of Employee's Return to Work _____

Periodic certification from Health Care Provider Dated: _____

Periodic certification from Health Care Provider Dated: _____

Physicians release for employee to return to work Dated: _____

GROUP HEALTH PLAN BENEFITS

	EMPLOYER CONTRIBUTION	EMPLOYEE CONTRIBUTION
MEDICAL		
DENTAL		
VISION		
LTD		
LIFE		
TOTALS		