DUNCANVILLE ISD

Writing success stories, one student at a time.

Medical Leave Request

Please complete this form and return it as soon as possible to the Human Resources Department at 710 S. Cedar Ridge, Duncanville, Texas 75137, or fax to 972-767-0971, or email to FML@duncanvilleisd.org.

Employee Name: _____ Start Leave Date: _____

Social Security #: _____ Return to Work Date: _____

Phone #: _____ Type of Leave: ☐ Continuous ☐ Intermittent

Email Address: _____ Employee's Position: _____

Emergency Contact: _____ Campus/Department: _____

Emergency Contact's Ph. #: _____ Supervisor: _____

Reason for requested leave (please select one):

☐ 1. Because of a serious health condition that makes the employee unable to perform the functions of the employee's job (medical certification of ability to perform job duties must be provided to the Human Resource office before returning to work).

☐ 2. For the birth of a son or daughter, and to care for the newborn child.

☐ 3. For placement with the employee of a son or daughter for adoption or foster care.

☐ 4. To care for the employee's spouse, son or daughter, or parent with a serious health condition; if yes, please provide name, relation and address of person with the serious health condition:

Name: _____

Relation: _____

Address: _____

☐ 5. Because of any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

☐ 6. To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next of kin of the service member.

Medical Certification is required for all of the above and must be turned in to the Human Resources office.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the District, until I provided medical certification, as appropriate.

Employee Signature _____ Date Signed _____

FOR HUMAN RESOURCES USE ONLY

Date Received by HR: _____ Date FMLA Letter Sent to Employee: _____

Notes: _____

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