

Comal Independent School District
Personnel Services Office
Employee Request for FMLA

NAME: _____

Hire Date: _____

SS NUMBER: _____

DATE: _____

SUBJ: Family Medical Leave

We have been made aware that starting on or about _____ you are/will be taking family medical leave due to:

- a. the birth of a son or daughter of the employee or in order to care for such child; or
- b. placement of a son or daughter with employee for adoption or foster care;
- c. a serious health condition that makes you unable to perform the essential functions of your job.
- d. a serious health condition affecting your spouse, child, parent, for which you are needed to provide care;

If "d", please state name and address of relative.

Are you requesting leave on an intermittent or reduced leave schedule? (Only applicable for reasons "c" or "d" above.) Yes No

Length of absence or date of anticipated return to work: _____

The Family Medical Leave Act (FMLA) allows up to twelve working weeks of unpaid leave in a 12-month period for the reasons listed above for eligible employees and under the certification of a health care provider. To be considered an "eligible employee", you must have worked for Comal Independent School District (CISD) for at least one year and for 1250 hours of actual on-the-job duty during the previous twelve-month period preceding your leave. This letter is to inform you that, as of this date:

- 1. You are eligible not eligible for leave under the FMLA.
- 2. This leave will will not be counted toward your annual FMLA leave entitlement.

If you are not eligible, the reason for the ineligibility is:

- Employed less than 12 months
- Worked less than 1250 hours in previous 12 month period

You will be required to furnish medical certification of a serious health condition. You must furnish this certification within two (2) weeks of receiving this notification.

Note: Employee has 30 days after birth/adoption to add child to district insurance plan.

According to policy, any sick/personal/vacation days you have available must be used concurrently with your FML. Please be aware that sick/personal leave days are given up front at the beginning of the school year, but are earned at the rate of one workday for each 18 workdays. This means that, according to board policy, for every 18 days of docked (unearned days) you will lose one of your sick leave days. These unearned days will be calculated, and your wages adjusted, at the end of the school year or at the time of termination. (Unearned, or docked, days are days that you are not at work or do not have accrued leave to cover.)

The FMLA guidelines allow that we shall continue to pay the District's portion of the health insurance premium for the specified period of time that you are on leave. However, for an extended leave, you will need to contact Employee Benefits to make arrangements for payment of any other deductions you might have (such as dependent coverage, dental insurance, etc.). Also, if applicable, deductions to the credit union, professional dues, and income protection plans may be affected.

If both spouses are employed by the District, combined family and medical leave for the birth, adoption, or placement of a child may be limited to a combined total of 12 workweeks.

Remember that an absence of more than FIVE consecutive workdays for personal illness required a medical certification and a release to return to work. An absence of more than five consecutive workdays for family illness also requires medical certification. If such certification is not received, your return to work may be delayed until the release is provided. These should be submitted to your campus secretary on the first day of your return to work.

() I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, for a period not to exceed six months, unless I elect to discontinue such coverage (during an eligible FMLA leave, the District will continue to pay its share of the employee premium for medical coverage). If at the end of that period, the employee continues to be on an unpaid leave of absence, COBRA coverage shall be offered. 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 because of the continuation, recurrence, or onset of a serious health condition, I will provide medical certification from the appropriate health care provider stating 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 provide medical certification, as appropriate.

() I understand I am not eligible for leave under the Family & Medical Leave Act for the reason shown on the preceding page. I also agree to pay my share and the District share of my medical insurance premium, should the circumstance occur, or forfeit my coverage.

If you have any questions, please contact Armando Maese (830-221-2181) or Valerie Galan (830-221-2102) in the Personnel Services Office.

Administrator Signature

Date

Employee Signature

Position/Campus

S. S. Number

