

LASALLE/PUTNAM COUNTY EDUCATIONAL ALLIANCE FOR SPECIAL EDUCATION

1009 Boyce Memorial Drive, Ottawa, Illinois 61350

PHONE/TDD: 815-433-6433 / FAX: 815-433-6164 / EMAIL: lease@lease-sped.org

REQUEST FOR FAMILY OR MEDICAL LEAVE

Request for Family or Medical Leave must be made at least thirty (30) days prior to the date of birth, adoption, or planned medical treatment. In the case of emergency, F.M.L.A. leave is to be requested as soon as practical. Please Print.

Name _____

Date _____

Department _____

Title _____

Status Full Time Part Time Temporary

Employee SSN _____

Hire Date _____

Length of Service _____

I. I request family or medical leave for one or more of the following reasons:

Birth or placement of a child for adoption or foster care provided the leave is concluded within 12 months from the date of birth/adoption.

Expected date of birth/adoption _____

Actual date of birth/adoption _____

Leave to start _____

Expected return date _____

In order to care for my spouse, child or parent who has a serious health condition.

Leave to start _____

Expected return date _____

For a serious health condition that makes me unable to perform my job. Describe:

Leave to start _____

Expected return date _____

* If leave is taken for a serious health condition, you must have your physician complete a "Certification of Health Care Provider" form. This certification should be provided within fifteen (15) days of the request.

For other reasons (describe): _____

II. Requested intermittent leave schedule (if applicable; subject to employer's approval) _____

III. Have you taken a family or medical leave in the past 12 months? ___ Y ___ N If Yes, how many workdays? _____

IV. I understand and agree to the following provisions:

1. I have worked for my employer at least one year and at least 1,250 hours in the previous 12 months.
2. If I fail to return to work after the leave (for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control) I will be financially responsible for the medical insurance premiums the organization paid while I was on leave.
3. This leave will be unpaid; or in the case of my own disability, payment will occur under any available disability insurance plan, if I am so covered. Family or personal illness leave may be taken intermittently if certified as medically necessary by a physician with the days/weeks totalling no more than twelve (12) work weeks.
4. I may be required to exhaust my paid vacation, personal or sick leave as part of my 12 weeks of leave.
5. After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

V. **Employee Signature** _____ **Date** _____

I understand that the electronic submission of this form by e-mail is the equivalent to my signature.