Application for Family and Medical Leave

Name:____ Bldg/Dept:_________

Current Address:____

Address City State Zip

Start Date of anticipated leave: ____

Expected Date of Return to Work:____

Reason for Leave:____

____

____

____

NOTE: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent ***must submit*** a verifying ***medical certification from a physician within 15 days of application for leave***.

I, ___________________________________ authorize a representative from Willard R-II Schools to contact my physician to verify the reason for my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Willard R-II Schools.

Signature:____ Date:______________

Approved by:

____

Supervisor Date

____

Payroll/Personnel Date