FORSYTH COUNTY SCHOOLS
REQUEST FOR FAMILY AND MEDICAL LEAVE OR DISABILITY LEAVE

This form is for two types of leave. *Family and Medical Leave* (FML) is available to qualifying employees for the purposes defined by Board of Education Policy GBRIG. *Disability Leave* may be available to employees in situations of personal disability *not covered* by FML. If you are going to be absent from work more than 10 consecutive workdays, you must: **1**) Complete "Employee" section below; **2**) have your *Health Care Provider* complete the "Certification" section below; and **3**) return completed form to: Forsyth County Schools, Human Resources Department, 1120 Dahlonega Hwy., Cumming, Georgia 30040. You may also FAX completed forms to: (770) 888-1121.

EMPLOYEE

Are you **updating** or **changing** a request already submitted? ☐Yes ☐ No. If **yes**, last request submitted on: ____/____/____

Employee Name: _____ Phone:_____ SSN: _____

Home Address: _____
STREET ADDRESS, CITY, STATE, ZIP CODE

Work Site: _____ Position Held: _____

Requesting leave from: _____/_____/_____ through: _____/_____/_____. I will be ready to return to work on: _____/_____/_____
FIRST DAY OUT **LAST** DAY OUT

The reason for leave is: _____

If any part of the leave is without pay, I prefer that deductions from pay be *(choose one)*: ☐**prorated** *(starting no later than the first paycheck after leave begins)* **OR** ☐ in a **lump sum** each month that unpaid absences occur *(leaving enough to cover benefit premiums)*. ☐ Off payroll.

Employee Signature: _____ Date: _____

Note to Employee: The school district will respond to your request on the opposite page or attached sheet. Please read the response carefully.

CERTIFICATION OF HEALTH CARE PROVIDER

Health care provider means a doctor of medicine, doctor of chiropractic, or doctor of osteopathy legally authorized to practice by the appropriate examining board. **Provider should complete either** Section **I** *OR* **II** *OR* **III** ***AND*** Section **IV**.

SECTION I - MATERNITY

•Anticipated Delivery date: _____

•Anticipated Period of post-partum disability: _____

If the patient has or is expected to have an abnormal medical condition during the pregnancy that warrants limitations in work-related activity or that requires a post-partum disability period of more than six weeks, please explain why.

_____
Attach additional page(s) if necessary.

SECTION II - EMPLOYEE DISABILITY

•Date Disability Commenced: _____

•Probable Duration or Ending Date: _____

Describe the serious health condition(s) that makes the employee unable to perform the essential functions of his/her job.

_____
Attach additional page(s) if necessary

SECTION III - CARE OF FAMILY MEMBER

Name of Family Member: _____

Date(s) employee's presence is necessary for care of family member: First Day _____ Last Day _____

Describe the serious health condition of the family member.

_____
Attach additional page(s) if necessary.

SECTION IV – HEALTH CARE PROVIDER

Provider's Name: _____ Phone: _____ License #: _____

Address: _____ City, State: _____

Signature: _____ Date: _____

═══ HUMAN RESOURCES ═══
RESPONSE TO REQUEST FOR FAMILY AND MEDICAL LEAVE OR DISABILITY LEAVE

Employee: _____ File No. _____

This is the response to your ☐**original** ☐**amended** request for leave dated: ____/____/____. If this is an ***amendment*** to terms previously approved, then any terms not changed below remain the same as last approved.

•Employee ☐**is** ☐is **not** eligible to take ***Family and Medical Leave*** (*FML*).

Eligible Dates: from _____/_____/_____ through _____/_____/_____
FIRST DAY OUT **LAST** DAY OUT

•Employee ☐**is** ☐is **not** eligible to take ***Disability Leave*** (non-*FML* leave).

Eligible Dates: from _____/_____/_____ through _____/_____/_____
FIRST DAY OUT **LAST** DAY OUT

Hire Date: _____/_____/_____

LEAVE BALANCE

Sick: _____

Annual: _____ N/A _____

FML Taken ____ Balance ____

Print Date _____/_____/_____

Last Posted _____/_____/_____

Computation: Total Days[1] _____ Days Out[2] _____ Allowable Leave[3] _____ Leave Without Pay[4] _____ Off Payroll_____

1. *Scheduled workdays in a full year.* **2**. *Workdays to be missed during leave.* **3**. *Maximum Sick Leave /Annual Leave days that may be used during the absence.* **4**. *Workdays during the absence that must be without pay (i.e., Sick Leave is unavailable or not permitted – see note below).*

NOTE: The following ***Sick Leave*** limitations ☐**do** ☐do **not** apply to your approved leave(s) of absence.

In certain situations, an employee may **not** be permitted to use available *Sick Leave* during a Family and Medical Leave absence. Georgia law (§20-2-850) provides that *Sick Leave* may be used [only] "for absences due to illness or injury or necessitated by exposure to contagious disease or to illness or death in the immediate family." Consequently, an employee on approved *FML* leave is *not* permitted to be paid from available *Sick Leave* on any days of absence not necessitated by one of the reasons specified by law. For example, an employee who takes 60 days of *FML* for maternity, but who is *disabled* for only 30 scheduled workdays (i.e., a "normal" delivery), would be permitted to use only 30 *Sick Leave* days even if more days are available.

All approved leaves of absence are subject to terms and conditions specified by district policies and the following:

- **FAMILY AND MEDICAL LEAVE**
  1. All *Family and Medical Leave* taken will be charged against your *FML* entitlement.
  2. You must use available *Sick Leave* and *Annual Leave (if applicable)* during the absence; however, the use of *Sick Leave* is limited to the number of *Allowable Leave* days specified above. *(See note in box above, if checked as applicable to you.)*
  3. You may be required to provide Forsyth County Schools with a release to return to work from the *Health Care Provider*.
  4. You must notify Human Resources in a written statement (with a copy to your supervisor) not less than 10 days or more than 20 days prior to the approved ending date of the leave:
     a. Whether or not you will return to work on the scheduled date approved in the response to your request.
     b. Whether or not you will present a *new* request for leave and the date such new request will be presented.
     c. Whether or not you will: **A**. *(if under professional employment contract)* request release from the contract pending recommendation of a suitable replacement or **B**. *(if not under contract)* resign from employment.

- **DISABILITY LEAVE**
  1. The purpose of Disability Leave is to help employees qualify for the disability premium rate for health care insurance. The terms and rights provided by FML do not apply to Disability Leave, including the right to return to work.
  2. The following statement ☐**does** ☐does **not** apply to any absence approved as Disability Leave:
     Since *Disability Leave* does not include a right to return to work, your active employment status has ended.

The request is a**pproved** as specified in the HUMAN RESOURCES section above.

By: _____ Date:_____

C: Benefits ● Payroll ● Supervisor ● Personnel ● Leave ● HR
Revised August 2009