Revised: 02/13/2024

DONNA INDEPENDENT SCHOOL DISTRICT
Request for Foreseeable Family and Medical Leave (FMLA)

"THE DISTRICT"

Name (Official Name): _____

Employee ID: _____ **Position:** _____

Campus/Department: _____

If leave is being requested for a serious medical condition of a child, spouse, parent or yourself, a statement from a licensed physician confirming the serious health condition must be submitted with this request for leave.

Number of weeks being requested *(Maximum of 12 weeks):* _____

Begin Date: _____ End Date: _____

To be used for:

I understand that under the Federal Family and Medical Leave Act, eligible employees are entitled to 12 weeks of job-protected, unpaid leave for the birth, adoption, or foster placement of a child; serious health condition of a child, spouse, or parent; or personal illness. I also understand that the District will maintain my health care benefits at the same level provided before leave began. ***(If you normally pay a portion of the premiums for your health insurance, you must continue to pay for these premiums just as you did before FMLA leave. You will also need to make arrangements for payment of any additional insurances that you may have.)***

I fully understand that if the Family and Medical Leave is granted, I will be granted up to 12 weeks of leave without loss of employee benefits.

Signature of Employee: _____ Date: _____

For Office Use Only!

Signature of Principal/Director: _____ Date: _____

Signature of HR Administrator: _____ Date: _____

Signature of Deputy Superintendent: _____ Date: _____

☐ **APPROVED** ☐ **DENIED**

Signature of Superintendent: _____ Date: _____