SANTA MARIA INDEPENDENT SCHOOL DISTRIC
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EMPLOYEE REQUEST FOR FORESEEABLE FAMILY AND MEDICAL LEAVE

1. Name of employee (First Name, Middle Initial, Last Name)	2. Employee's position

3. Reason for requested leave.

a. ☐ Birth of a child, or placement of a child with you for adoption or foster care

b. ☐ Employee's own serious health condition

c. ☐ Because you are needed to care for your ☐ spouse, ☐ child, ☐ parent due to his/her serious health condition

d. ☐ Because of a qualifying exigency arising out of the fact that your spouse; son or daughter; parent is on active duty or status in support of a contingency operation as a member of the National Guard or Reserves.

e. ☐ Because you are the ☐ spouse; ☐ son or daughter; ☐ parent; ☐ next of kin of a covered service-member with a serious injury or illness.

4. Date on which you wish to commence leave:	5. Date of anticipated return to work:
6. Are you requesting leave on an intermittent or reduced leave schedule? ☐ Yes ☐ No	7. If "yes," please give schedule of when you anticipate you will be unavailable for work:

An employee seeking leave because of reason "3(b)" or "3(c)" above must provide medical certification within 15 calendar days.

An employee seeking leave because of reason "3(d)" or "3(e)" above must provide qualifying exigency certification within 15 calendar days.

An employee seeking to return to work after a leave because of his or her own serious illness [reason "3(b)"] also must provide a medical certification of ability to perform job duties before being allowed to resume work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. 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 to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expires or that I am needed to care for my spouse/parent/child because he or she has a serious health condition on the date that my leave expires. I understand that I may not be permitted to resume my position with the ESC until I provide medical certification, as appropriate.

Signed Date