VISTA UNIFIED SCHOOL DISTRICT
FAMILY CARE MEDICAL LEAVE PLACEMENT

Please Print

EMPLOYEE NAME: ________________________________ EMPLOYEE I.D.#____________________

SITE: ___________________________________ POSITION: ___________________________________

HIRE DATE: _____________☐ Full Time ☐ Part Time STATUS: ☐ Tenured ☐ Prob.1 ☐ Prob. 2

REASON FOR LEAVE

Family Care and Medical Leave (FMLA) Unpaid leave Employee must be employed for 12 months or 1250 hours prior to leave.	Requested dates for Family Medical Leave:
☐ Serious Health Condition of Employee (self) **OR** ☐ Serious Health Condition of Family Member	FMLA Start: ____________________________ FMLA End: ____________________________ (not to exceed 12 workweeks/60 workdays)
If leave is for serious health condition of immediate family member, the name and relationship of the family member is: Name of Family Member: _________________ Relationship to Employee: ________________	**Please note:** ▪ Medical coverage remains intact. ▪ FMLA runs concurrently with any paid leave.
Please note: ▪ A leave for a serious health condition for yourself or an immediate family member requires a **physician's statement** submitted to the Human Relations department.	**Return to work effective date**: ____

DISTRICT AUTHORIZATION

LEAVE REQUESTED ☐ APPROVED ☐ DENIED

________________________________ ________________________________

Assistant Superintendent, Human Relations Date