Employee Request for Leave Form

Please complete and email to FMLA@baycityisd.org, attn: LEAVE

Please follow the instructions in the "Employee Section" below to notify Bay City ISD of your request for leave. Employees seeking leave because of reason (c) or (d) below, must provide medical certification within 15 days, or as soon as practicable. The medical certification will be sent to you within 5 days. Employees seeking to return to work after a leave because of their own serious illness [reason (d)], also must provide medical certification of ability to perform job duties before they are allowed to resume work.

Employee Section
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Last Name:	First Name:	Bay City ISD ID#
Campus/Dept:	Position:	Last 4 Digits Social Security #:

Reason for Requested Leave (check one):

- ☐ (a)Birth of a son or daughter of the employee, and leave to care for such son or daughter
- ☐ (b)Placement of a son or daughter with employee for adoption or foster care
- ☐ (c)To care for spouse, child, or parent with a serious health condition
- ☐ (d)Because of employee's own serious condition that makes him/her unable to perform job functions

If (c), please check one: ☐ Spouse ☐ Child ☐ Parent	If (c), state name & address of relative:
Date on which you wish leave to commence:	Date of anticipated return to work:
Are you requesting leave on a full-time or intermittent basis? ☐ full-time ☐ intermittent	If intermittent, please give a schedule of when you anticipate you will be unavailable for 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 expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the district until I provide medical certification, as appropriate.

Employee Signature:	Date:

Human Resources Date Received:
Received by (intials):

Revised
06/06/2023