

# Request for Family or Medical Leave

ARLINGTON SCHOOL DISTRICT  
OFFICE OF HUMAN RESOURCES  
696 Dutchess Turnpike, Poughkeepsie, NY 12603  
845-486-4460

## PLEASE PRINT AND RETURN TO YOUR PRINCIPAL/SUPERVISOR

Request for Family or Medical Leave shall be made at least 30 days prior to the date the requested leave is to begin.

Name \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (street, city, state) \_\_\_\_\_

Phone Number \_\_\_\_\_

Position \_\_\_\_\_

Status:  Full time  Part Time  Temporary

Unit \_\_\_\_\_

Hire Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Building \_\_\_\_\_

Length of Service \_\_\_\_\_

I request family or medical leave for one or more of the following reasons:

**Because of the birth of my child and in order to care for him or her.**

Expected date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Actual date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Leave to start \_\_\_\_/\_\_\_\_/\_\_\_\_

Expected return date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Because of the placement of a child with me for adoption or foster care.**

Date of placement \_\_\_\_/\_\_\_\_/\_\_\_\_

Leave to start \_\_\_\_/\_\_\_\_/\_\_\_\_

Expected return date \_\_\_\_/\_\_\_\_/\_\_\_\_

**In order to care for my spouse, child or parent, who has a serious health condition.\***

Leave to start \_\_\_\_/\_\_\_\_/\_\_\_\_

Expected return date \_\_\_\_/\_\_\_\_/\_\_\_\_

**For a serious health condition that makes me unable to perform my job.\* Describe:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Leave to start \_\_\_\_/\_\_\_\_/\_\_\_\_

Expected return date \_\_\_\_/\_\_\_\_/\_\_\_\_

**For other reasons. Describe:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Leave to start \_\_\_\_/\_\_\_\_/\_\_\_\_

Expected return date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Requested intermittent leave schedule (if applicable; subject to employer's approval). Describe:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\* A physician's certification may be required for leave due to a serious health condition.

I understand and agree to the following provisions:

- I have worked for my employer at least one year and at least 1,250 hours in the previous 12 months.
- If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, and if my employer requires it, I will be financially responsible for the medical insurance premiums the company paid while I was on leave.
- This leave will be unpaid, unless it is District policy to be paid; or in the case of my own disability, payment will occur under a company disability insurance plan, if I am so covered.
- I may be required to exhaust my paid vacation, personal or sick leave as part of my 12 weeks of leave.
- After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

I have taken a family medical leave in the past 12 months?  Yes  No

I have used \_\_\_\_\_ number of workdays

Employee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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### Leave Approval *(for office use only)*

**For full day leave:**

Principal/Supervisor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**For intermittent or reduced day leave:**

Principal/Supervisor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Human Resources Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Notes: \_\_\_\_\_

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### Payroll Instructions *(for office use only)*

Manager/Supervisor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

With pay from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Without pay from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments: \_\_\_\_\_