SIOUX CITY COMMUNITY SCHOOL DISTRICT

FAMILY MEDICAL LEAVE ACT (FMLA) REQUEST LETTER

DATE _____

TO: Kim Smith, Benefits Manager
627 4th St.
Sioux City IA 51101
(712) 279-6692 Ext 6121

Eligibility for Family and Medical Leave:
Employed by Sioux City Community School District for at least one year and worked 1,250 hours in the past 12 months.

Dear Mrs. Smith,

This letter is to request a leave of absence for a medical qualifying event under the Family Medical Leave Act (FMLA).

I expect that my leave will begin on _____ and continue through _____.

The leave is for: ____ My serious health condition or injury
____ Illness of family member…….Relationship _____
____ Birth, adoption, foster care

I understand that I am required to complete a Certification of Health Care Provider form and submit it to Kim Smith, Benefits Manager, before my leave commences. I understand that if my leave is approved, my time away from work will be charged against my 12-week leave maximum under FMLA. Upon approval, I am required to utilize all appropriate paid time available to me prior to going into an unpaid leave status. In the event that I go into an unpaid status while on leave, I understand that I must contact Mrs. Smith to make arrangements to pay my portion (if any) of health insurance premiums.

I request the following forms for my leave of absence:

1. Notification of FMLA Status: This is to notify me that the Sioux City Community School District is designating the leave as FMLA leave and to inform me in writing of the specific expectations and obligations required by the District under FMLA.

2. Personal Illness Leave Form/Medical Certification: This form is to be completed by either my health care provider (if this leave is for my own serious health condition) or by my family member's health care provider (if this leave is for the serious health condition of a spouse, parent, or child). ***My physician must complete this entire form. Failure to complete this form may delay my leave approval.***

I understand that the medical leave form should be returned to Kim Smith, Benefits Manager, within 15 days after receiving the notification. If I am not able to return the form within the allowed timeframe, I will contact Mrs. Smith for assistance.

If this information is not received in the required time frame, my leave may be considered unauthorized.

Sincerely,

EMPLOYEE SIGNATURE _____

PRINT NAME _____

ADDRESS _____

TELEPHONE # _____

POSITION AND BUILDING _____