

Personnel & Student Services Department

P.O. Box 305 \* Bethel, Alaska 99559

907 543-4886p / 907 543-4900f

[www.lksd.org](http://www.lksd.org)

Actual date FML began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected End of FML \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Actual Return Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUEST FOR FAMILY/MEDICAL LEAVE (FMLA)**

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position Title: \_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hrs/day (or FTE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request Family/Medical Leave for the following reason (check one):

\_\_\_\_\_\_\_ A. Pregnancy, the birth of a child and in order to care for such child or the placement of a child with the employee for adoption or foster care. Maximum time available is 12 weeks with restrictions. (Complete this side only).

\_\_\_\_\_\_\_B. Employee’s own serious health condition that requires in-patient care or the continuing treatment or supervision by a health care provider, provided the employee is unable to perform the functions of his/her position. Doctor’s recommendation required. Maximum 12 weeks. **(Physician must complete LKSD Long Term Sick Leave form #PSS-Leave-02.)**

\_\_\_\_\_\_\_C. Circle one: SPOUSE – CHILD – PARENT In order to care for an immediate family member if such family member has a serious health condition that requires in-patient care or the continuing treatment or supervision by a health care provider. Doctor’s recommendation is required. Maximum 12 weeks. Provide an estimate of the time period during which this care will be provided. Include a schedule if leave is to be taken intermittently or on a reduced schedule:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**(Physician must complete LKSD Long Term Sick Leave form #PSS-Leave-03.)**

Method of leave options (available for B. and C. above only):

\_\_\_\_\_\_\_ Option (a) Consecutive Leave (check or leave blank)

\_\_\_\_\_\_\_ Option (b) Intermittent (or reduced) leave schedule. Please provide explanation:

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**Date leave is to begin (approximate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected duration \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Use of Leave\*:** Family/Medical Leave is unpaid. However, the District substitutes all accrued sick leave and annual leave (except for Certified employees) prior to any unpaid Family/Medical Leave. Use of sick leave and annual leave is subject to the restriction of the employee’s negotiated agreement. Periods of paid leave run concurrently with Family/Medical leave entitlement. While on FMLA status, you have job protection and employer provided Health Insurance. Be sure you understand COBRA health benefits in relationship to Family/Medical leave.

If the duration of my family/medical leave (total of paid and unpaid leave time) does not exceed 12 weeks (or up to 18 weeks on approved AFLA), I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks, I will be returned to the same or similar position only if available, in accordance with applicable leave laws and contractual agreements. I understand that if I fail to return from unpaid family/medical leave for reasons other than (1) the continuation, recurrence or onset of a serious health condition of the employee or a covered family member or (2) circumstances beyond the employee’s control (certification required within 30 days of failure to return for either reason), LKSD may seek reimbursement from the employee for the portion of the insurance costs paid by the District on behalf of that employee during the period of unpaid leave.

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Employee’s Signature Date Site Administrator Date

\_\_\_\_\_\_\_ Approved \_\_\_\_\_\_\_ Not Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Superintendent’s Designee Date

\_\_\_\_\_\_\_ I request to extend my leave under Alaska Family Leave Act (AFLA) for an additional 6 weeks, with the same conditions as FMLA.