FMLA	
180 DATE	
60 DATE	

ALIEF INDEPENDENT SCHOOL DISTRICT
LEAVE OF ABSENCE FORM

Complete the relevant sections of this form and have your supervisor sign it and submit the form to HR with the Health Care Provider certification or note. The supervisor's signature is required and is only an acknowledgement of the request, not an approval. For questions, contact the Leaves Specialist at **281-498-8110 ext. 29153**.

Employee Information

Employee Name (First & Last name):	**Date:**
Employee ID #:	**Campus/Department:**
Contact Number: **Cell #:**	**Personal Email:**
Job Title:	**Supervisor's Name:**

Leave Request Information

First Day of Leave (Required):___________________ Date of Estimated Return (Required):________________________

I am requesting a (check one):

☐ **Family Medical Leave (FML) - Eligibility Determined by HR**
☐ **Temporary Disability Leave (TDL)**
☐ **Military Leave (FML)**
☐ **Other (office use only)**
☐ **Intermittent Leave of Absence (smaller blocks of time ranging from a few hours to a few days at a time)**
Please provide an estimate of your leave dates of when you will be unavailable to work (only if eligible for FML).
_____________Day(s) or ___________Hours

(Employees must provide medical certification within 15 days)

Reason for Request

☐ **Self:** leave for your own serious health condition, including pregnancy
For Pregnancy or Adoption - anticipated date of birth or placement: ________________________.

Is leave due to an on-the-job injury? ☐ Yes ☐ No

☐ **Family:** leave due to a family member's serious health condition, or parental leave (Spouse, Child or Parent)
Relationship of family member to you: ________________________ If son or daughter, provide date of birth: ___________________.

Is leave due to an injury/illness associated with a family member's military service? ☐ Yes ☐ No

☐ **Military:** family member called to active duty (Certification of Qualifying Exigency form must be completed to document the need for leave)

X____
Employee's Signature Date

I understand that I am responsible for paying my insurance when I am no longer receiving paychecks for earned pay.

X____
Principal/Supervisor's Signature Date

This is only an acknowledgment of the request, not an approval by the supervisor.

OFFICE USE ONLY:

____
HR Administrator's approval

____
Date of Board Notification