

MADISON LOCAL SCHOOL DISTRICT
MANSFIELD, OHIO

APPLICATION FOR FAMILY AND MEDICAL LEAVE

Name _____ Date _____

Building or department _____

I hereby request a leave of absence for the following reasons:

- _____ Personal Illness
- _____ Illness of child, parent or spouse
- _____ Care of newborn child
- _____ Care of newly adopted or placed foster child

for the following period:

from _____ until _____

This leave will be with/without pay (circle one). Family Medical Leave is provided for a maximum of twelve weeks during one 12 month period. I will be provided with the same medical, dental and life insurance during this leave. If I elect to take this leave without pay, then I will pay the District Treasurer my share of the insurance premium no later than the first day of each calendar month while on leave.

Signature

Approved _____

Disapproved _____

Date _____

Superintendent

- A medical statement from a licensed physician stating that the leave is medically necessary will need to be provided with this form.
- A medical release from a licensed physician stating that the physician is releasing the patient will be required as a condition of return to work.