Middlesex County Vocational and Technical School System

Request for Leave Under the Family and Medical Leave Act

Name: ___________________________________ School: ______________________________________

Home Address: ____

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Start Date of Anticipated Leave: ____

Expected Date of Return to Work: ____

Reason for Leave (Explain): ____

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NOTE:

An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician for the leave to be considered under the Family and Medical Leave Act.

I hereby authorize Middlesex County Vocational and Technical Schools to contact my physician to verify the reason for my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing.

Signature: ___________________________________ Date: ______________________

Employees must provide 30 days notice if foreseeable, otherwise what is practical if it is an emergency. Requests must be submitted to your building administrator together with the Medical Certificate before a determination can be made regarding to granting of a leave under the FMLA. Once you have submitted your Request form and Medical Certificate, a timely response will be made concerning your request.

CERTIFICATION of PHYSICIAN under the FAMILY and MEDICAL LEAVE ACT

1. Employee's Name:	2. Relationship to Employee:

3.Diagnosis:____

4. Date condition commenced:	5. Probable duration of condition:

6. Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services.) Include schedule of visits or treatment if it is medically necessary for the employee to be off from work.

a. By Physician:

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b. By another provider of health services, if referred by Physician:

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IF THIS CERTIFICATION RELATES TO CARE FOR AN EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 7,8 AND 9 AND PROCEED TO ITEMS 10 THROUGH 17. OTHERWISE CONTINUE BELOW.

CHECK Yes or No in the boxes below, as appropriate:

	Yes	No	
7.	O	O	Is inpatient hospitalization of the employee required?
8.	O	O	Is employee able to perform work of any kind? (If "No", skip Item 9.)
9.	O	O	Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

10. Name (PLEASE PRINT) and Signature of Physician:	11. Date

12. Type of Practice (Field of Specialization, if any):

Address:
Telephone Number:

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS 10 THROUGH 17 BELOW AS THEY APPLY TO THE FAMILY MEMBER.

	Yes	No	
13.	O	O	Is in patient hospitalization of the family member required?
14.	O	O	Does (or will) the patient require assistance for basic medical, hygiene, nutritional or safety needs?
15.	O	O	After review of the employee's signed statement (See Item 17 below), is the employee's presence necessary for the care of the patient?

16. Estimate the period of time that care is needed or the employee's presence would be beneficial:

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TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

17. When the Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule.

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MEDICAL RELEASE:

I authorize the release to Middlesex County Vocational and Technical High Schools of any medical information necessary to process this request.

Patient's Signature: ______________________________ Date: ____________________