Clint Independent School District
Employee Request for FMLA Leave Form

1. Name of Employee: (First Name, Middle Initial, Last Name)	Phone:
2. Employee's Position\Campus:	

3. Reason for requested leave:

(A) ☐ To care for the employee's child after birth, or placement for adoption or foster care;

(B) ☐ To care for the employee's spouse, child or parent, who has a serious health condition; or

(C) ☐ For a serious health condition that makes the employee unable to perform the employee's essential job function.

4. Date on which you wish or intend to commence leave:	5. Date of anticipated return:

6. Are you requesting leave on an intermittent or reduced schedule:

☐ Yes ☐ No

7. If "yes" please give schedule of when you anticipate you will be unavailable:

Employees requesting leave because of reason "3(B)" above will be required to provide medical certification within 15 days of employer's notice to employee.

Employees seeking to return to work after a leave of absence because of their own serious illness (reason "3(C)") also must provide a fitness for duty certification before they are allowed to resume job duties.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse Clint ISD for the cost of health care benefits provided to me during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the essential job functions of my position on the date that my leave expired or that I am needed to care for my spouse/child/parent because he or she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my job duties with the District until I provide the required medical certification, as deemed appropriate by the District.

Employee Signature: _____ Date: _____

Upon completion please forward this form to the contact below. Please direct all questions to the same contact.

Clint ISD, Benefits Coordinator
Department of Human Resources \ Benefits
14521 Horizon Blvd.
El Paso, TX 79928
Phone (915) 926-4073 Fax (915) 926-4079

Received By: _____ Date Received: _____