

**SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL  
COOPERATIVE**

REQUEST TO APPLY FOR FAMILY AND MEDICAL LEAVE

Employee Name \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
School \_\_\_\_\_ Supervising Teacher \_\_\_\_\_

**Request is for:** (Please check one)

- \_\_\_\_\_ The birth or placement of a son or daughter for adoption or foster care;  
\_\_\_\_\_ The need to care for a spouse, son, daughter or parent of the employee because of a serious health condition (*requires medical certification*); or  
\_\_\_\_\_ A serious health condition of the employee that prevents the employee from performing their job functions. (*requires medical certification with an anticipated date of returning to work*)

**NOTE: If FMLA is requested for the care of a seriously ill family member the following information must be provided:**

**Name of spouse, son, daughter or parent & explanation of relationship:**

**Briefly explain reason for leave request:**

**Anticipated dates of leave:** From: \_\_\_\_\_ Through: \_\_\_\_\_  
(Please include a proposed schedule if you are requesting an irregular leave or leave on a reduced work schedule)

- \* *I certify that I have been provided information on FMLA policies & procedures.*
- \* *I agree to and meet the requirements and conditions of the Family Medical Leave Act of 1993.*
- \* *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 requested, agreed upon and approved in writing by the agency.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Request for FMLA received by: \_\_\_\_\_ Date \_\_\_\_\_  
Director / Assistant Director