Rock Hill Schools
Medical Leave Request
(Adoption, Military, FMLA-medical/maternity)

PART I

Employee Name:	Date:
Location:	Job Title (include Grade, Subject, or Assignment if applicable):

I request a family or medical leave for one or more of the following reasons:

☐ Because of the birth of my child and in order to care for him or her. Expected Date of Birth_____

☐ Because of the placement of a child with me for adoption or foster care. Date of Placement _____

☐ In order to care for my spouse, child, or parent, who has a serious health condition.

☐ For a serious health condition that makes me unable to perform my job.

☐ Due to a qualifying exigency arising out of spouse, child, or parent, who is on active duty, or has been notified of impending call to active duty in support of a contingency operation-attach form WH-384.

☐ Military Caregiver Leave; to care for my spouse, child, or parent who is recovering from a serious illness or injury sustained in the line of duty while on active duty - attach form WH-385.

☐ Intermittent Leave: Non-continuous leave that protects an employee's job if they need to take time off for qualifying reasons (self, spouse, child or parent).

Leave to start _____ **Expected return date** _____

I understand and agree to the following:

1. If I fail to return to work after the leave, I will be financially be responsible for overpayments in any benefits plan (i.e., medical insurance) administered by the District.
2. During this leave, I will use my accumulated standard sick leave (District policy allows 30 days for birth or adoption of child) including the days advanced to me this school year. Any remaining absences will be unpaid.
3. I will contact my supervisor or Assistant Superintendent of Human Resources on or before my expected date of return if I am unable to return as scheduled.

Employee Signature _____ **Date** _____

Human Resources Associate _____ **Date** _____

Employee Well-Being Manager _____ **Date** _____

PART II **Physician, Adoption Counselor or Military Official - Statement of Disability/Adoption/Military Status**

Explanation of Need for Leave _____

_____

Anticipated
Start Date of Leave: _____

Approximate
Date of **Return** to Work: _____

_____
Printed Name of Doctor, Adoption Counselor or Military Official

_____
Signature of Doctor, Adoption Counselor or Military Official

_____
Current Date

_____
Phone Number

_____
Street Address

_____
City State Zip Code

PART III **Request for Termination of Medical Leave – to be completed prior to returning to work**

(Physician must complete this section ***if*** leave is based on a serious health condition of the Employee.
If leave is ***not*** based on health condition of employee, the physician's release below is not necessary).

This is to certify that _____ has been examined by me and found to be physically and emotionally fit for resumption of his/her duties as a _____ on _____

_____ _____
Date **Physician's Signature**

This is to advise Human Resources that I am available to return to an active status on _____

_____ _____
Date **Employee's Signature**