

## REQUEST FOR FAMILY OR MEDICAL LEAVE

### Employee Notification

Request for Family or Medical Leave must be made in writing, if practical, at least 30 days prior to the date the requested leave is to begin.

Name Trevla Cain Date 4/21/14  
School Whittier Position Media Assistant

I request a family or medical leave for one or more of the following reasons. I understand that a physician's certification and all required information must be submitted before this request is processed.

☒ Because of the birth of my child, or because of the placement of a child with me for adoption or foster care.

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

☐ For a serious health condition that makes me unable to perform my job. THIS CONDITION ☐ IS ☐ IS NOT WORK RELATED.

☐ Requested intermittent or reduced leave scheduled \_\_\_\_\_

Leave to start 4/30/14 Expected return date 8/1/14

- ☒ I would like to use my sick/personal days  
☐ I would not like to use my sick/personal days  
☒ Original request for leave  
☐ Request for extended leave

Employee Signature Trevla Cain Date \_\_\_\_\_

### LEAVE APPROVAL

Principal/Designee Signature [Signature] Date 4-28-14

Superintendent Signature [Signature] Date 5-5-14

Board Secretary Signature \_\_\_\_\_ Date \_\_\_\_\_

Board President Signature \_\_\_\_\_ Date \_\_\_\_\_

Sick Days - 16.5 Personal Days - 1.0

04-30-14P03:05 RCVD

Southwest  
Women's  
Healthcare  
ASSOCIATES

TIPHNE N. SHARPE, APN  
BOARD CERTIFIED WOMEN'S HEALTHCARE  
3700 W. 203rd Street, Suite 110  
Olympia Fields, IL 60461 708.679.1890

Name Trevla Cain RX # \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_

Phone \_\_\_\_\_ Date 4/17/14

**R**

This patient is under  
our care for her pregnancy  
Her estimated due date  
is 5/28/2014

☐ May Substitute Typh/Orange APN - WENT RG M.D.  
☐ May Not Substitute \_\_\_\_\_ M.D.

Refill \_\_\_\_\_ times

DEA # \_\_\_\_\_