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 Sylvia A. Smith-Lottie (aka Sylvia A. Lottie) Date 8-31-15

School Lowell-Longfellow Position Educator, Grade 3

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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~~. *To be determined.

✓ Requested intermittent or reduced leave scheduled 8/31/15 through 10/31/15*

*...may need intermittent time off for exacerbation of her medical condition consisting of 2--3 times a month needing 1 -- 2 days off...

Leave to start __/__/__ Expected return date __/__/__

✓ 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 (See doctor's statement)

Intermittent Leave

Employee Signature Sylvia Smith-Lottie Date 8-31-15

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LEAVE APPROVAL

Principal/Designee Signature [signature] Date 9/4/15

Superintendent Signature [signature] Date 9/10/15

Board Secretary Signature _____ Date _____

Board President Signature _____ Date _____

Sick Days - 44.5

Franciscan
PHYSICIAN NETWORK

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Name Sylvia Smith-Lottie Date 8-28-15
Address

℞ Phone D.O.B. Allergy

FILL GENERICALLY UNLESS OTHERWISE INDICATED

The patient has been under my care. She is cleared to return to work without restrictions but may need intermittent Time Off for exacerbation of her medical condition consisting of as much as 2-3 times a month needing 1-2 days off. This will take apart for approximately

☐ May Not Substitute
☐ May Substitute D.O. M.D.

Refill | NR | 1 | 2 | 3 | 4 | 5 | 6Mo | 1Year | CASH | INS | HMO | CHG | SCD | EMP

INDICATION

PATIENT CONSULTATION | YES | NO

Franciscan
PHYSICIAN NETWORK

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Name Sylvia Smith-Lottie Date 8-28-15
Address

℞ Phone D.O.B. Allergy

FILL GENERICALLY UNLESS OTHERWISE INDICATED

2 months while she is still receiving treatment and specialist evaluation.

☐ May Not Substitute
☐ May Substitute G Jimenez D.O. M.D.

Refill | NR | 1 | 2 | 3 | 4 | 5 | 6Mo | 1Year | CASH | INS | HMO | CHG | SCD | EMP

INDICATION

PATIENT CONSULTATION | YES | NO