

**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 Bridgett Williams Date 9/8/15

School Class Program Position Para pro

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 9/9/15 Expected return date 11/24/15

- 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 Bridgett Williams Date 9/8/15

**LEAVE APPROVAL**

Principal/Designee Signature [Signature] Date 9-8-15

Superintendent Signature [Signature] Date 9/16/15

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

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

Sick Days - 11.5

09-09-15P03:22 RCVD

**JAMES D. SCHLENKER, M.D., S.C.**  
**Plastic Surgery and Hand Specialists, Inc.**  
6311 W. 95<sup>th</sup> Street  
Oak Lawn, IL 60453-2267  
(708) 423-2258  
FAX (708) 423-2305

DATE: 9/16/15  
TO: Human Resources  
COMPANY: Harvey School District  
FAX: 708-231-9845

TIME: 12:30 pm  
FROM: Medical Records

NUMBER OF PAGES 1  
(Including Cover)

RE: BRIDGET WILLIAMS  
Here is the approximate time off.

Date of Surgery: 9/9/15

**JAMES D. SCHLENKER, M.D., S.C.**

6311 W. 95TH STREET • OAK LAWN, IL 60453

**JAMES D. SCHLENKER, M.D.**

PHONE: (708) 423-2258

**ROBERT E. SCHLENKER, M.D.**

FAX: (708) 423-2305

NAME Bridget Williams DATE 9-15-15  
ADDRESS \_\_\_\_\_ AGE \_\_\_\_\_

**Rx** Above patient off work  
for approximately 11 weeks  
(from date of surgery)

DO NOT REFILL

MAY SUBSTITUTE

MAY NOT SUBSTITUTE

REFILL \_\_\_\_\_ TIMES



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