RAINIER SCHOOL DISTRICT

360.446.2207
FAX: 360.446.2918
207 CENTRE ST S
PO BOX 98
RAINIER, WA 98576

# APPLICATION FOR MEDICAL LEAVE

Employees must provide the District at least 30 days advance notice of the request for medical leave. If your leave is unforeseen, notice must be provided as soon as you are able. The following information will be used in determining your leave options and eligibility.

***Please complete this form and return it to Human Resources within 5 days.***

_____ _____ _____
Employee Name | Job Title | Location/School

_____ _____
Contact Email | Contact Phone Number

1. **I am requesting Medical Leave for the following reason:**
   - ☐ Birth of a child, or placement of a child with me for adoption or foster care, to bond with newborn;
   - ☐ My own serious health condition;
   - ☐ To care for the following family member during their serious health condition:
     - ☐ Spouse ☐ Child ☐ Parent ☐ _____
   - ☐ Because of a qualifying exigency arising from the fact that my ☐ Spouse; ☐ Son/Daughter; ☐ Parent is a military member on covered active duty or call to covered active duty status.
2. **Leave Request:**
   Begin Date: _____ End Date: _____
   ☐ Continuous Leave or ☐ Intermittent Leave/Reduced Work Schedule
3. **Medical Certification:** If a physician's certification is provided, I may use my accrued leave if available. If a physician's certification is not provided, my time off may be denied and my leave will be unpaid.
4. **Please apply the following accrued leave while on Medical Leave:**
   ☐ Sick Leave ☐ Vacation ☐ Personal Leave ☐ Unpaid Only
5. **Benefits:** I understand that my group health care benefits will be continued, under the same terms and conditions currently being maintained, if eligible for FMLA leave. If my status becomes unpaid, I may not be entitled to the continuation of group health insurance coverage.
6. **Physician's Release:** Upon return to work, I will provide a physcians's release authorizing my return to work if the leave was for my own serious health condition or birth of a child.
7. **Coverage (if applicable):** I understand that I need to arrange substitute coverage with my building administrator or supervisor. I further understand that intermittent leave will require an approved schedule by my building administrator or supervisor. If it is determined that intermittent leave will cause a hardship or disruption to the classroom, continuous leave may be granted in lieu of intermittent leave.
8. **Notification:** I have notified my building administrator of my upcoming medical leave.

I agree to immediately notify the District of changes in circumstance relating to my medical leave.

_____ _____
Signature of Employee | Date