

JASPER COUNTY BOARD OF EDUCATION

Request For Family Leave

(Please type or print clearly in ink.)

Employee MUST complete Part 1, Part 2, AND Part 3.
CERTIFICATION / DOCUMENTATION

** PART 1 **

EMPLOYEE IDENTIFICATION

Employee Name _____

Address _____

City, State _____ Zip Code _____

Social Security Number _____ Home Telephone Number _____

** PART 2 **

Family Leave is available to qualifying employees for the purposes of childbirth, adoption, or foster care placement, care of the employee's child, spouse, parent, and for personal disability.

I am requesting Family Leave: from _____ Beginning Date to _____ Ending Date

I am requesting my previously approved Family Leave be extended through _____ Ending Date

** PART 3 **

I am requesting Family Leave for the following reason:

Birth of a Child - Name of mother _____

Adoption / Foster Care Placement - Name of child _____ ; Date of placement _____

Care of Family Member - Name _____ ; Relationship _____ Child, _____ Spouse, _____ Parent

Personal Disability

HEALTH CARE PROVIDER MUST COMPLETE CERTIFICATION ON PAGE 2.

Employee Signature

Date of Employee Signature / Request

SUPERVISOR'S RESPONSE

Approved

Modified

Denied

Supervisor's Signature

Date of Supervisor's Signature

JASPER COUNTY BOARD OF EDUCATION
Request For Family Leave
(Please type or print clearly in ink.)
Health Care Provider **MUST** complete Part 4 AND Part 5 OR Part 6

**** PART 4 ****
IDENTIFICATION OF HEALTH CARE PROVIDER

Physician's Name _____
Address _____
City, State _____ Zip Code _____
Telephone Number _____ License Number _____

**** PART 5 ****
CARE OF FAMILY MEMBER

Name of Family Member _____ Relationship to Employee _____
Date(s) employee presence necessary for family member: from _____ to _____
Beginning Date Ending Date

Describe the serious health condition of family member. Attach additional page(s) if necessary:

**** PART 6 ****
EMPLOYEE DISABILITY

Employee Name _____
Date The Disability Commenced _____ Probable Duration or Ending Date _____

Describe the serious health condition that makes the employee unable to perform the essential functions of his/her employment. Attach additional page(s) if necessary:

Signature of Health Care Provider

Date of Health Care Provider's Signature

JASPER COUNTY BOARD OF EDUCATION
Family Leave

Supervisor's Response

To: _____

Date: _____

From: _____

I have reviewed your application for Family Leave. The request is modified or denied for the reason(s) indicated below:

You have the right to appeal this decision to Dr. Mike Newton, Jasper County School Superintendent.

Your appeal, including a copy of the original request, all supporting documentation, and a copy of this letter must be filed with the person indicated above within three (3) workdays of your receipt of this decision. If you fail to file an appeal within three (3) workdays, you will forfeit all further right of appeal, including any appeal to the Board of Education.

Signature of Supervisor

Title of Supervisor



Response To Appeal

To: _____

Date: _____

From: _____

I have reviewed your appeal of the modification or denial of your application for Family Leave. My decision and the reason(s) for the decision is indicated below:

You have the right to appeal this decision to the Board of Education. Your appeal must be filed with me within three (3) workdays of your receipt of this decision. Upon receipt of your request, I will immediately forward your appeal to the Board of Education. If you fail to file an appeal within three (3) workdays, you will forfeit any further right of appeal.

Signature

Title