

MILTON PUBLIC SCHOOLS  
MILTON, MA 02186

**REQUEST FOR FAMILY OR MEDICAL LEAVE**

Please Print

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

Name \_\_\_\_\_ Date: \_\_\_\_\_

Department: \_\_\_\_\_ Title: \_\_\_\_\_

Status:  Full Time  Part Time  Temporary

Hire Date: \_\_\_\_\_ Length of Service: \_\_\_\_\_

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I request family or medical leave for one or more of the following reasons:

Because of the birth of my child and in order to care for him or her.

Expected date of birth \_\_\_\_\_ Actual date of birth \_\_\_\_\_

Leave to start \_\_\_\_\_ Expected return date \_\_\_\_\_

Because of the placement of a child with me for adoption or foster care. Date of placement \_\_\_\_\_

Leave to start \_\_\_\_\_ Expected return date \_\_\_\_\_

In order to care for my spouse, child or parent with a serious health condition.

Leave to start \_\_\_\_\_ Expected return date: \_\_\_\_\_

For a serious health condition that makes me unable to perform my job. Describe: \_\_\_\_\_

\_\_\_\_\_

Leave to start \_\_\_\_\_ Expected return date \_\_\_\_\_

For other reasons. Describe: \_\_\_\_\_

\_\_\_\_\_

Leave to start \_\_\_\_\_ Expected return date \_\_\_\_\_

Requested intermittent leave schedule (if applicable; subject to employer's approval) \_\_\_\_\_

\_\_\_\_\_

Have you taken a family leave in the past 12 months?  Yes  No

If yes, how many workdays? \_\_\_\_\_

I understand and agree to the following provisions:

- I have worked for the school department at least one year and at least 1,250 hours in the previous 12 months.
- If I fail to return to work after the leave for reasons other than the continuation, recurrence or onset of a serious health condition that would entitle me to Medical Leave or other circumstances beyond my control, and if the school department requires it, I will be financially responsible for the medical insurance premiums that the town paid while I was on leave.
- This leave will be unpaid.
- I may be required to exhaust my paid vacation, personal or sick leave as part of my 12 weeks of leave.
- After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Leave Approval**

For full day leave:

Supervisor/Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For intermittent or reduced day leave:

Supervisor/Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Human Resources Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: \_\_\_\_\_

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**Payroll Instructions**

With pay from: \_\_\_\_\_ to: \_\_\_\_\_

Without pay from: \_\_\_\_\_ to: \_\_\_\_\_

Comments: \_\_\_\_\_

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\_\_\_\_\_