

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 unless your Collective Bargaining Agreement allows for it to be paid. In that case, we will assume you will use sick time to cover this absence unless you tell us otherwise
- 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: _____

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: _____

Payroll Instructions

With pay from: _____ to: _____

Without pay from: _____ to: _____

Comments: _____
