Please provide the information requested and submit the completed form to:

Oxford Human Resources Office
10 N. Washington Street, Oxford, MI 48371
248.969.5090 / Fax 248.969.5013

Application for Family and Medical Leave

Employee Name: ______________________________________

Position/Bldg.: ______________________________________

Date: ______________________________________

See attached form for benefit plan elections.

Type of Leave Requested
(Check one box)

☐ Employee Medical Leave of Absence
☐ Extension of Employee Medical Leave of Absence
Dates of prior approved Medical Leave: ____________ to _____________
☐ Family Member Medical Leave of Absence
☐ Extension of Employee Family Member Medical Leave of Absence
Dates of prior approved Employee Medical Leave: _____________ to _____________
☐ Leave to care for newborn or adopted child/child placed for adoption.
☐ For qualifying exigency (Military).
☐ To care for a Military service family member with a serious injury or illness.

The leave (or extension) is to begin on _______________ and end on _________________

If the request is for an intermittent leave, the dates and/or times of the leave are as follows:

____

For all intermittent leaves, a physician statement is required for all absences

NOTE: A leave or extension of leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent <u>must be accompanied with the completed, attached Certification of Health Care Provider.</u> Failure to provide the medical certification within a reasonable time (within 15 calendar days of occurrence) may result in a delay or denial of the requested leave. In addition, failure to provide the requested certification within 15 days of the request may result in a termination of employment. Failure to return to work at the end of an approval leave period will be treated as a resignation unless an extension has been agreed upon and approved in writing.

I agree to reimburse the cost of medical premiums should I sever employment, subject to the exceptions as outlined in the Family and Medical Leave Act Rules and Regulations.

____ ____________________________
Employee Signature Date

Approved by:

____ ____________________________
Asst. Superintendent Date

Application for Family and Medical Leave (continued)

Paid time off election:

☐ I elect to use accrued sick days that I have accumulated
☐ I elect **not** to use accrued sick days that I have accumulated

☐ I elect to use accrued vacation days that I have accumulated
☐ I elect **not** to use accrued vacation days that I have accumulated

Health care coverage election:

☐ I would like to continue health care coverage (if applicable) for:
 ☐ Myself
 ☐ Myself and currently covered dependents

☐ I would like to discontinue coverage while on approved Family Medical Leave

I understand that I am responsible for my share of the cost of the coverage. I agree to contact the Human Resources Department prior to the start of my leave to make arrangements for payment while on leave.

Other benefit plan election:

If coverage under my other benefit plans is available, please:

☐ Continue my coverage while on leave
☐ **Discontinue** my coverage while on leave

If coverage is elected, I understand that I am responsible for my share of the cost of the coverage. I agree to contact the Human Resources Department prior to the start of my leave to make arrangements for payment while on leave.