

**TAZEWELL-MASON COUNTIES SPECIAL EDUCATION ASSOCIATION
APPLICATION FOR FMLA LEAVE**

Employee Name: _____ Date of Hire: _____

Dept: _____ Position: _____

Any Prior Requests for FMLA Leave: ___ Yes ___ No If so, when: _____

Length of FMLA Leave Requested: _____ (maximum of 12 weeks)

Date FMLA Leave Will Begin: _____ Expected Date of Return: _____

I am requesting FMLA Leave for the following qualifying event:

- ___ birth of a child, or placement of a child with you for adoption or foster care
- ___ serious health condition that makes you unable to perform the essential functions of your job
- ___ serious health condition affecting your spouse/child/parent (circle one), for which you are needed to provide care

Description of Qualifying Event: _____

A medical certification from a physician should be submitted on the “FMLA Certification of Health Care Provider” form with this application which confirms and sets forth the nature of the serious health condition if this is the qualifying event.

An employee must have been employed by the Association for at least 12 months, working at least 1,250 hours during the 12-month period immediately preceding a FMLA request, in order to be eligible for FMLA leave.

If you are a “key employee” as described in Section 825.217 of the FMLA regulations (a salaried employee paid among the highest 10% of all Association employees), you should consult the Executive Director before proceeding with this application.

I understand that I will be required to take paid leave, sick or vacation leave, before becoming eligible to receive unpaid leave. I certify that the information which I have provided is accurate and truthful to the best of my knowledge. Employee’s Initials: _____

Employee Signature: _____ Date: _____

Submit this application to your Department Head.

Signature of Person Receiving this Application: _____

Title: _____ Date: _____