Lake Forest Academy
Family and Medical Leave Request Form

Employee: _____   Date: _____

Job Title: _____   Supervisor: _____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons, with exception to a leave of absence for an injured service member in which an employee may take up to 26 weeks. Lake Forest Academy (LFA) has elected to pay up to 12 weeks of absence through Short-Term Disability. Employees are expected to utilize all sick and vacation pay prior to Short-Term Disability pay. Submit this request form to your supervisor at least 30 days prior to commencing the leave. When submission of the request form 30 days in advance is not practical, submit the form as early as possible. Lake Forest Academy reserves the right to deny or postpone leave for failure to give appropriate notice when denial/postponement would be permitted under federal or Illinois law. In accordance with such laws, it is necessary to submit physician documentation of the illness and of the need for the employee to be the caregiver. In cases of your own illness, for absences in excess of one week, it is necessary to furnish a medical certificate signed by a physician, verifying that you are able to return to work. Employees on approved FMLA leave may not work for another employer during their FMLA leave program. Failure to adhere to these rules may result in forfeiture of the job-protection benefit of FMLA.

Eligibility

1. [ ] YES   [ ] NO
   Whether they were consecutive or not, have you work for LFA for a total of 12 months or more?
   If "yes", continue to next step. If "no", stop here, you are ineligible for FMLA.

2. [ ] YES   [ ] NO
   During the past 12 months, have you worked at least 1,250 hours (approximately eight months of 40-hour weeks or one year of 25-hour weeks)?
   If "yes", continue to next step. If "no", stop here, you are ineligible for FMLA.

3. [ ] YES   [ ] NO
   Have you previously received medical or family leave? If "yes", provide the information requested below.

   Dates of leave: From _____ To and including _____

   Purpose of leave: _____

   _____

Reasons for Requesting Leave

Leave must be granted for any of the following reasons:

- the employee's own serious health condition makes the employee unable to work
- to care for a spouse, child, or parent who has a serious health condition
- to care for a newborn, newly-adopted child, or recently-placed foster child
- to care for a parent, child, spouse or next of kin who is an injured service member
- a qualifying exigency arises out of the employee's parent, child or spouse being on active duty or being called to active duty

I am requesting leave for the following reason:

[ ]   Personal serious health condition

[ ]   Serious health condition of:

Spouse Name: _____

Child Name: _____

Parent Name: _____

[ ] Birth of a Child

Expected delivery date: _____

[ ] Adoption or placement of a child for foster care

Child's Name: _____

Scheduled Date of adoption or placement: _____

Dates of Leave Requested

I request leave from _____ to _____

I request intermittent leave according to the following schedule: _____

_____

I request a reduced schedule leave according to the following schedule: _____

_____

_____

The total amount of business days that I am request is: _____

Employee Statement

I agree to return to work on (date) _____. If circumstances change such that I will not be able to return to work on the above date, I agree to inform my supervisor by submitting a notice to employer of changes in approved medical or family leave and complete any appropriate form in an expeditious manner. I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

Signed: _____ Date: _____

To be completed by Supervisor

Employee started in this department on (date): _____

Employee is [ ] Full-time   [ ] Part-time

How will the employee's duties and responsibilities be handled in your unit and in LFA during the employee's leave of absence?

_____

_____

_____

Employee has previously requested family or medical leave   [ ] Yes   [ ] No

I   [ ] recommend [ ] do not recommend

the request of FMLA for _____ from (date) _____ to _____

Supervisor Name: _____ Date: _____

Signature: _____ Telephone # _____

To be completed by Human Resources

Prior Leave requests confirmed: (Initials) _____ Eligibility Confirmed: (Initials) _____

This request for FMLA is   [ ] Approved

                                   [ ] Denied for the following reason: _____

_____

_____

Signed: _____ Date: _____