**TEACHER REQUEST FOR MEDICAL LEAVE**

**Employee Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Position**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Estimated Date of Leave**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **to** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employees are required to use their eligible sick time while on a leave. Please refer to your collective bargaining agreement for details. If medical leave is for the birth of a child, employee has **30 days from the date of the birth** to enroll in health care benefits.

\_\_\_\_\_ I understand that it is my obligation to ensure that Ann Arbor Public Schools Human Resource Department receives the Health Care Provider Certification Form and any other supportive documentation requested in order to make FMLA determination and that a request for leave does not guarantee approval.

\_\_\_\_\_ I understand that the Ann Arbor Public Schools, or a health care representative of their choosing, may review the Health Care Provider Certification Form and contact my health care provider to clarify the information provided on the form.

\_\_\_\_\_ I understand that in the case of incomplete or insufficient information, I can request that my employer provide me with a written list of questions for me to take to my provider. It would be my responsibility to ensure that the provider documents on the form the information needed to resolve the insufficiencies and that it is returned by the deadline assigned by AAPS.

\_\_\_\_\_ Although I have the right set forth in #2 above, I authorize Ann Arbor Public Schools or The Heaney Group, acting on their behalf, to contact my provider directly to resolve any insufficiencies.
 **YES** **NO**

**Note:** Authorization granted above may be revoked at any time by submitting a request, in writing, to the Human Resources Department.

\_\_\_\_\_ I have read and reviewed the Collective Bargaining Agreement sections on use of the Teacher Common Sick Bank and formally request that my case be submitted for consideration of its use. I understand that a request for use does not guarantee that Teacher Common Sick Bank will be granted.

 **YES** **NO**

\_\_\_\_\_ I authorize the Human Resources Department to disclose the pertinent details of my case to the Teacher Common Sick Bank Committee in an effort to determine if my case meets the criteria for use of the Teacher Common Sick Bank. **YES** **NO**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Employee:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**This form must be returned to Human Resources Services within 48 hours of a request for leave**