**EMPLOYEE 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 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 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 information needed to resolve the insufficiencies.

\_\_\_\_\_ Although I have the right set forth in #2 above, I authorize the Heaney Group to contact my provider to resolve the insufficiencies.

 **YES** **NO**

\_\_\_\_\_ I understand that I may revoke this authorization in writing at any time by contacting the HR Department. I further understand that if I do not sign this form or revoke previous authorization that I may not be eligible for Family Medical Leave benefits if I have not submitted certification.

Note: If we try to contact your provider with your authorization and your provider does not respond or provide us with complete and sufficient information, we may return the form to you for you to attempt further contact. I understand it is ultimately my obligation to ensure that the employer receives this information in order to make FMLA determination.

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

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

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

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

This form must be returned to Human Resources Services at least

**15 days prior to beginning of leave or request may be denied.**