



Extended Leave/FMLA Application *(Extended Paid Leave, FMLA, and JPAL)*

Complete and submit this form to the Office of Integrated Disability Leave Management. Applications for leave must be made at least 30 days in advance of the leave period, except in unforeseen circumstances. AACPS reserves the right to deny requests or postpone leave when insufficient notice of leave is provided.

EMPLOYEE INFORMATION

Name		Employee ID
Job Title	Work Location	Supervisor Name

TYPE OF LEAVE

Reason for Requested Leave (Check one box)

- A. Birth of my son or daughter and in order to care for such son or daughter *(indicate estimated due date below)*
- B. Placement of a son or daughter with me for adoption or foster care.
- C. To care for my spouse, child (age _____), or family member with a serious health condition.
 Name of Family Member: _____
 Relationship to Employee: _____
- D. My own serious health condition which makes me unable to perform the functions of my position.

Leave for **types A and B** must be taken within the first 12 months of birth or placement and may not be taken intermittently or on a reduced leave schedule.

Leave **type B** will be processed only upon receipt of appropriate documentation.

Leave for **types C or D** will be processed only upon receipt of a completed medical certification.

A Return to Work Medical Certification form must be completed and submitted to the Office of Integrated Disability and Leave Management Office (FAX 443.458.0140) before you may return to work from **type D**.

AMOUNT OF LEAVE

- I request that **continuous leave** be granted for the following period of time:

Beginning on: _____ Ending on: _____
(date) (date)

- I request **intermittent** leave as follows (indicate schedule for treatment and/or frequency of absences for appointments/flare-ups):

FMLA is unpaid. If you are FMLA eligible and you have sick leave available, your sick leave will be used simultaneously with your FMLA leave. After your sick leave is exhausted, if you have additional paid leave available, and want to use it with your FMLA leave, please make your choices below.

- | | |
|--|--|
| Annual Leave | Personal Business Days |
| <input type="checkbox"/> none | <input type="checkbox"/> none |
| <input type="checkbox"/> all | <input type="checkbox"/> all |
| <input type="checkbox"/> _____ (# of days) | <input type="checkbox"/> _____ (# of days) |

EMPLOYEE CERTIFICATION & SIGNATURE

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that misrepresentation or omission of the reason for leave or any of the facts supporting the need for leave may result in denial of the leave and will subject me to discipline up to and including termination.

Employee Signature

Date

Employee Address

Employee Phone