MARBLE FALLS INDEPENDENT SCHOOL DISTRICT

Human Resources Department
1800 Colt Circle, Marble Falls, Texas 78654
Phone: 830-693-4357 ext.1109
Email: ealmazan@mfisd.txed.net

MFISD

EMPLOYEE REQUEST FOR LEAVE

Employee must select one option:

- O Family Medical Leave (FML) – Employee is eligible if employed by MFISD for at least one year and worked at least 1250 hours during the previous year.
- O Assault Leave (FML) – An employee who is physically assaulted at work and sustained an injury as a result, may apply for assault leave. Eligibility is determined after an investigation.
- O Temporary Disability Leave (TDL) – A full-time educator is eligible for reasons of own personal serious health condition. Employee shall be returned to active duty, subject to the availability of an appropriate position, no later than the beginning of the next school year.
- O Military Leave (ML) – Employee may apply for military leave due to serious injury or illness of a covered service member. An employee may also apply for military leave due to qualifying exigency.

(Type or Print)

1. Employee Name (First, Middle Initial, Last Name)		2. Telephone Number
3. Job Title	4. Campus/Department	5. Supervisor

6. Circle the Reason for requested leave:
   a. Birth of child (Does not apply to TDL)
   b. Placement of a child with employee for adoption or foster care (Does not apply to TDL)
   c. To care for spouse, child, or parent with serious health condition (Does not apply to TDL)
   d. Employee's own serious health condition that makes him/her unable to perform job function.
   e. Military Leave

Please check one:
O Self O Spouse O Child O PARENT

7. Date Leave will begin:	8. Date of anticipated return to work:
9. Are you requesting continuous or intermittent leave?	10. If requesting intermittent, please provide a work schedule of when you anticipate you will be unavailable for work. (not required, but preferred)

_____ _____
Employee Signature Date Principal/Supervisor Signature Date

PLEASE RETURN VIA FAX TO: 830-693-5685 ATTN: Human Resources Benefits & Wellness Specialist

HUMAN RESOURCES USE ONLY:

_____ _____
Human Resources Administrator Signature Date

Marble Falls ISD has an unyielding commitment to love every child and inspire them to achieve their fullest potential.

AUTHORIZATION TO RECEIVE PERSONAL HEALTH INFORMATION

Employee's Name: _____

Social Security #: XXX-XX-_____

Patient's Name: _____

Patient's Date of Birth: _____

Relationship to Member: _____

Employee's Authorization for Self or Minor Family Member

I am the employee described above, I hereby authorize the Marble Falls ISD to receive personal health information regarding any physical and/or mental health condition of myself or my minor family member named above as patient for the purpose of determining my eligibility for Family and Medical Leave.

Signature of Member:_____ Date Signed: _____

Adult Patient's Authorization (Family Member)

I am the adult patient described above and named in the Marble Falls ISD employee's request for leave. I hereby authorize the Marble Falls ISD to receive personal health information regarding my physical and/or mental health condition for the purpose of determining the employee's eligibility for Family and Medical Leave request.

Signature of Adult Patient:_____ Date Signed: _____

PLEASE RETURN FORM TO:

Benefits Specialist, Human Resources Department
1800 Colt Circle, Marble Falls, Texas 78654
Phone: 830-693-4357 ext.1109
Email: ealmazan@mfisd.txed.net

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EMPLOYEE INFORMATION*

(to be completed by the employee).

Complete the Employee Information portion below. The attending physician must fully complete the remainder of the form. A request for Family Medical and Leave or Temporary Disability Leave will **not** be considered until the **Physician's Statement** is received.

Employee Name: _____

Campus/Dept.: _____Date: _____

Patient's Name: _____ Relationship: _____

MEDICAL CERTIFICATION*

(to be completed by the attending physician) See attached Job Description.

Please complete the following information regarding the patient named above.

Describe illness or injury in lay terms: _____

_____

Date of diagnosis: _____/_____/_____

Check all that apply:

The patient's illness, injury, or condition: ❒ is life threatening, ❒ requires in-patient hospitalization, and/or ❒ is expected to result in disability or death.

Explain the short-term/long-term prognosis: _____

_____

Is it medically necessary for the employee to be absent from work due to this condition? Yes/No Please Explain: ___

_____

_____

Is patient still under your care? ❒ Yes ❒ No Date Patient will be able to return to work _____/_____/_____

Hospitalization: Name and address of hospital: _____

_____

Date admitted: _____/_____/_____ Date discharged: _____/_____/_____

Name of attending physician: _____

Address: _____

Phone: _____ Fax: _____

I certify that the information given on this Attending Physician's Statement is accurate and true.

Physician's Signature: _____ Date: _____

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* Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

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RELEASE TO RETURN TO WORK

Patient's name: _____

Date the employee is approved to return to work: _____(IF APPLICABLE)

RESTRICTIONS OR LIMITATIONS? __NONE __ SCHEDULE __ ACTIVITY

NATURE OF RESTRICTIONS OR LIMITATIONS:

_____

_____

EXPECT TO RETURN TO FULL FUNCTION? __ YES __ NO

I have examined the employee and can certify to the best of my knowledge, and within the limitations if any listed above, that the patient named here is, or on the approved return date will be able to resume working and perform all the essential functions of his/her job.

_____ _____

Physician signature Date

Physician's information please print:

Name: _____

Address: _____

Phone: _____ Fax: _____

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