

**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**

Employ	vee	must	select	one	option:
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- 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.
- 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.
- 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.
- 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)			
Employee Name (First, Middle Initial, Last Name)		2. Telephone Number	
3. Job Title	4. Campus/Department		5. Supervisor
c. To care for spouse, child, o		ion (Does not apply to TDL)	
O Self O Spouse O Child	O PARENT		
7. Date Leave will begin:	- 770231	8. Date of anticipated ret	urn to work:
9. Are you requesting continuous or inte	rmittent leave?		ent, please provide a work schedule of when you unavailable for work. (not required, but preferred)
Employee Signature	Date	Principal/Supervisor Signa	ature Date
PLEASE RETURN VIA FAX		N: Human Resources B	enefits & Welllness Specialist
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 Se	elf or Minor Family Member					
I am the employee described above, I hereby authorize information regarding any physical and/or mental health named above as patient for the purpose of determining	h condition of myself or my minor family member					
Signature of Member:	Date Signed:					
Adult Patient's Authorization (Family Member)						
I am the <u>adult patient</u> described above and named in the I hereby authorize the Marble Falls ISD to receive persond/or mental health condition for the purpose of determedical Leave request.	onal health information regarding my physical					
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

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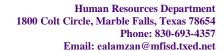
#### **EMPLOYEE INFORMATION\***

(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.

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

<sup>\*</sup> 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).





# **MFISD**

## **RELEASE TO RETURN TO WORK**

Patient's name:	<u></u>					
Date the employee is approved to return to w	/ork:	_(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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