

## La Porte Independent School District Medical Leave Request Form

Employee	Employ	ee #
Campus/Department	Position	
Home Address Street		Zip Code
Cell Phone Home Phone		
<ol> <li>Reason for requested leave:         <ul> <li>aBirth of a son or daughter of the employee at the son or daughter with employee for the son or daughter with</li></ul></li></ol>	for adoption or foster or with a serious health or condition that makes	care. condition.
2. If "c" check one:SpouseChildI	Parent	
3. If "c" name		relation
city/state		zip code
Date on which you wish leave to commence		
Date of anticipated return to work		
Employees seeking leave because of reason "1c" or as soon as possible.	"1d" above must prov	vide medical certification within 15 days or
Employees seeking to return to work after a leave provide a medical certification of ability to perform du I may not be permitted to resume my position with the	uties before they are a	allowed to resume work. I understand that
I understand that the 12-month period within which medical leave shall be defined as the 12-month perion understand that I shall be required to use all applical paid state and local leave will be used in the order leave, when applicable, concurrently with the family a	iod beginning on July able paid leave and, u r determined by Boar	1 thru June 30 of the school year. I also inless I request a different order, available
I hereby agree that while I am on leave, I will continue to discontinue such coverage. I also agree that if reimburse the District for the cost of health benef because of the continuation, recurrence, or onset of beyond my control. If I am unable to return to work certification from the appropriate health care proving position on the date that my leave expired or that I as has a serious health condition on the date that my leave.	f I fail to return to w fits provided during of f a serious health con k because of a serio ider stating that I ar am needed to care fo	ork at the end of the leave period, I will my leave, unless I fail to return to work ndition or because of other circumstances us health condition, I will provide medical n unable to perform the functions of my
Employee Signature	Date	