



**SCHOOL DISTRICT OF LODI
FAMILY OR MEDICAL LEAVE REQUEST FORM**

Name: _____ Position: _____

Is full time leave being requested? ☐ Yes ☐ No

Dates you are requesting family or medical leave: From: ____/____/____ To: ____/____/____

Reason for Leave:

- ☐ The birth of my child and to care for the child. Actual or expected date of birth: ____/____/____
- ☐ The placement of a child with me for adoption, foster care or pre-condition of adoption (circle one). Actual or expected date of placement: ____/____/____
- ☐ To care for my spouse, son, daughter, or parent (circle one), who has a serious health condition (physician's or practitioner's certification may be required).
- ☐ My own serious health condition (physician's or practitioner's certification may be required).
- ☐ Because of a qualifying exigency arising out of the fact that my spouse, son, daughter or parent is on active duty or has been notified of a call or order to active duty in the Armed Forces in support of a contingency operation.
- ☐ To care for a covered service member who is my spouse, son, daughter, parent or next of kin.

Intermittent Leave Requested (Not full days): If you are requesting intermittent leave or a reduced schedule, please explain in the space provided and show the schedule of intermittent leave you are requesting:

Are you requesting paid leave? ☐ Yes ☐ No

If yes, please list which type(s) of paid leave are you requesting and the amount of each.

I certify that the above information is accurate and complete.

Employee Signature: _____ Date: ____/____/____

*Please return this form to the Business Manager as soon as possible.