DYERSBURG CITY SCHOOLS

509 Lake Road, Dyersburg, TN 38024 (731) 286-3600 Fax (731) 286-2754

Family & Medical Leave Act (FMLA)
Employee Request

Employees must submit this form at least 30 days prior to the desired start date of leave, if applicable, or within 48 hours if leave has already begun

_____ _____ _____
Employee Name (Please Print) Social Security # Phone

_____ _____
Position School/Location

Last Day of Work: _____ _____ _____
Month Day Year

Anticipated Return Date: _____ _____ _____
Month Day Year

REASON FOR LEAVE:

☐ Birth of a child, or placement of a child with you for adoption or foster care
If you are adding your child to your health insurance with Dyersburg City Schools, please be aware the plan requires that the child be added with 30 days from the date of the child's birth. Please initial: _____

☐ Health Condition ☐ Self ☐ Family Member: Specify _____

☐ Military Leave ☐ Self ☐ Family Member: Specify _____

☐ Other: Specify _____

***Incomplete forms or forms without supporting documentation will not be processed.**

Healthcare Provider Form Attached? ☐ Yes ☐ No Have you notified your Supervisor? ☐ Yes ☐ No
Is this foreseeable leave? ☐ Yes ☐ No If yes, are you providing a 30-day notice? ☐ Yes ☐ No

If leave is unforeseeable, please provide date of event that necessitated your leave: _____

BENEFITS: While on unpaid FMLA, DCS continues to pay the employer portion of health benefits. You are required to continue payments for your portion of the premium just as if you were not on leave.

I understand that by completing these forms, I am requesting FMLA leave. I agree to provide the required completed FMLA Certification of Health Care Provider form to the Personnel Director before my leave begins, if possible. If I do not provide this form, I understand that DCS can either delay the start of my leave or deny my leave. I understand if DCS approves my FMLA leave, my time away from work will count against my 12 week FMLA entitlement for the 12 month leave year.

Please sign below to acknowledge and confirm all the information on this form and the notice provided previously.

I AGREE TO:

- Continue paying my share of group health care & voluntary premiums
- Report periodically regarding my status and intent to return to work 5 days prior to FMLA ending
- Provide a medical certification of my fitness to work or inability to return to work at least 5 days prior to FMLA ending

_____ _____
Employee Signature Date