EASTERN NC SCHOOL FOR THE DEAF
Application for Family and Medical Leave

Employee Name: _____ **BEACON ID #**: _____

Address/Phone # during Absence: _____

Area/Division/Section: _____

Reason for the Leave Request:

_____ Serious Health Condition of employee
_____ Serious Health Condition of Family Member
_____ Adoption of Child/Foster Care – anticipated adoption/foster care date: _____
_____ Birth of a Child – anticipated due date: _____
_____ Exigency Leave
_____ Military Caregiver Leave

Leave Type (check one): Intermittent _____ Continuous _____
Leave Request Dates: **From** _____ **to** _____

Indicate below if you wish to use leave to cover your absence:
(Family and Medical Leave is unpaid leave for an absence of up to twelve weeks. The employee may receive income during this period by exhausting available sick, vacation, and bonus leave.)

_____ Vacation – number of hours _____
_____ Bonus leave – number of hours _____
_____ Sick leave* – number of hours _____
*For the employee's illness, the employee shall exhaust available sick leave and may choose to exhaust available vacation, or any portion, before going on leave without pay.

Certification:
Certification of leave taken for the adoption of a child may be supported by reasonable proof of adoption. Certification of leave taken for the birth of a child, illness of employee's spouse, child, or parent, or an employee illness shall be in the form of a **physician's statement** indicating the date of onset and medical condition requiring leave. Certification for exigency leave will be copy of military member's federal active duty orders for contingency operation and information related to a specific exigency activity. Certification for Military Caregiver leave will be a health care provider's statement or Department of Defense representative statement.

Physician's Statement can be mailed directly to:	**Human Resources Director** **Eastern NC School for the Deaf**
Or securely faxed to:	**1311 US Hwy. 301 South**
HR Director @ 252-234-1145	**Wilson, NC 27893-6621**

Applicant:
If I fail to return to work after the period of leave to which I am entitled has expired for a reason other than the continuation, recurrence, or onset of a serious health condition or other circumstances beyond my control, I will be required to repay insurance premiums paid by the State.

_____ _____
Signature of Applicant Date

Signature acknowledging receipt of FMLA request:

_____ _____
Signature of Supervisor Date

_____ _____
Signature of School Director Date

Approval of FMLA request:

_____ _____
Signature of Human Resources Manager Date

Instructions: Employee completes form, acquires appropriate signatures, and submits to Human Resources Director for final approval.