MIS Form #306
Rev. 05/18

District School Board of Pasco County
Request for Family Medical Leave (FMLA)
Office for Human Resources and Educator Quality
7227 Land O' Lakes Boulevard, Land O' Lakes, Florida 34638

Please type or print clearly. To be completed by employee.

Employee's Name: _____ _____
LAST FIRST MIDDLE EMPLOYEE ID# ***or*** LAST 4 DIGITS of SSN

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Work Location: _____ **Job Title:** _____ ◯ **Inst.** ◯ **Noninst.** ◯ **Admin.**

Unpaid FMLA Leave is requested for the following reason:

◯ 1. The birth of a child (son or daughter), and care following the child's birth.

Date or *expected* date of birth _____

◯ 2. The adoption of a child, including the events and process leading to the adoption, and care following the adoption.

◯ 3. The placement and/or care of a child in the foster care of the employee.

◯ 4. The care of a child, spouse, or parent of the employee who has a serious health condition.
Attach a completed ***Certification of Health Care Provider for Family Member's Serious Health Condition*** *(MIS Form #307-D)*

◯ 5. The treatment of a serious health condition which prevents the employee from performing the functions of his/her job (including serious health conditions related to pregnancy).
Attach a completed ***Certification of Health Care Provider for Employee's Serious Health Condition*** *(MIS Form #307)*

Unpaid FMLA Leave is requested as follows:

◯ Continuous Leave: Approximate Dates _____ _____
BEGINNING THROUGH

◯ Intermittent Schedule (**See instructions below regarding schedule of anticipated Leave.)

◯ Reduced Schedule to ___ hours per day, or to ___ days per week.
(Hours per day or days per week must be consistent per pay period. ** See instructions below regarding schedule of anticipated Leave.)

**For Leave which is requested on either an "Intermittent" schedule or a "Reduced" schedule under reasons 4 or 5 (that is, for the serious health condition of the employee or eligible family member), attach the proper MIS Form (#307 or #307-D) completed by the physician, which clearly indicates the intermittent or reduced schedule and the medical necessity for such a schedule.

FOR DISTRICT REVIEW/APPROVAL ONLY:

◯ **1250 hours**

◯ **Employed one year**

This form may be faxed (813-794-2078) or emailed (myleaves@pasco.k12.fl.us) to the Office forHuman Resources and Educator Quality (HREQ), Leaves Administration Section