EMPLOYEE REQUEST FOR LEAVE FORM

RETURN TO:
Bay City Independent School District
520 7th Street
Bay City, TX 77414
Attn: Assistant Superintendent

1. Name of Employee (First, Middle Initial and Last)	2. Employee's Position
3. Employee Social Security Number:	4. Employee's Campus/Department:
5. Reason for requested leave a. [ ] Birth of a son or daughter of the employee and leave to care for such son or daughter. b. [ ] Placement of a son or daughter with employee for adoption or foster care. c. [ ] To care for spouse, child, or parent with a serious health condition. d. [ ] Because of employee's own serious condition that makes him/her unable to perform job functions.	
6. If "c", please check one: [ ].Spouse [ ] Child [ ] Parent	7. If "c", state name and address of relative.
8. Date on which you wish leave to commence	9. Date of anticipated return to work
10. Are you requesting leave on a full-time or Intermittent basis? [ ] Full-time [ ] Intermittent	11. If Intermittent, please give schedule of when you anticipate you will be unavailable for work.
Employees seeking leave because of reason 5(c) or 5(d) above must provide medical certification within 15 days or as soon as practicable. The medical certification will be sent to you within 5 days. Employees seeking to return to work after a leave because of their own serious illness [reason 5(d)] also must provide medical certification of ability to perform job duties before they are allowed to resume work.	
I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the District until I provide medical certification, as appropriate.	
Employee Signature:	Date: