

**Family Medical Leave Request Form**  
***Rappahannock County Public Schools***

**To Be Completed by the Employee:**

1. Please complete this form to request Family Medical Leave.
2. Get a signed and dated medical statement from your doctor stating the reason for your request. (Diagnosis of serious personal health condition, the birth, adoption, or foster care placement of a child, or the care of an immediate family member.) The statement should include the projected beginning date of the absence and the projected returning date from the absence.
3. Discuss this information with your Principal or Supervisor.
4. Call to schedule a conference with the Assistant Superintendent of Human Resources.
5. Bring this completed form and the medical statement signed by your doctor to the conference.

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\_\_\_\_\_  
Employee's First, Middle, and Last Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street or Road Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Mailing Address if different from above

\_\_\_\_\_  
Job Title

\_\_\_\_\_  
Work Location

\_\_\_\_\_  
Home phone number

\_\_\_\_\_  
Cell phone number

\_\_\_\_\_  
Home e-mail address if available

\_\_\_\_\_  
Projected beginning date of leave

\_\_\_\_\_  
Projected return date from leave

\_\_\_\_\_  
Reason for leave as stated on attached Medical Statement

\_\_\_\_ Requesting to use Leave Days

\_\_\_\_ Requesting to use Leave without pay

\_\_\_\_\_  
Signature of Employee

**HR Use Only:** Copies to \_\_\_Personnel File \_\_\_Finance \_\_\_Supervisor

BHG 2008