The GLOBE Academy
Global Learning Opportunities through Balanced Education

REQUEST FOR FAMILY AND MEDICAL LEAVE

Name: _____ Social Security: _____

Date of Employment: _____

Is Your Spouse Employed by GLOBE? _____ YES _____NO

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Leave is Requested For:

Serious illness of: ___Employee ___Spouse ___Child ___Parent ___Parent in-law

___Birth of a Child ___Adoption ___Placement of a foster child

Date (or expected date) of birth, adoption, placement of a foster child: _____
(Month/Day/Year)

Attach Medical Certification to this Form for Leave Requested

---

Leave is requested starting: _____

Last Day Worked: _____

Do you intend to return to work after the leave? _____Yes _____No

If yes, expected date of return: _____

A Medical Release is Needed Prior to Returning to Work

Have you taken any other FMLA leave or other leave of absence during the past twelve months? ____Yes ____No

If yes, From _____ To _____ Reason for Leave _____

Note: An Employee must take paid leave including any accrued vacation and sick/personal leave first before beginning unpaid leave. Unless otherwise required, no employee will be entitled to more than a total of 12 weeks, paid and/or unpaid, for leave that qualifies under the FMLA.

Signature of Employee: _____ Date: _____

Signature of Head of School/Executive Director: _____ Date: _____