Hall County Schools
CHARACTER · COMPETENCY · RIGOR FOR ALL

711 Green Street N. W.
Gainesville, Georgia 30501-3368
Telephone: 770-534-1080
Fax: 770-287-2062

REQUEST FOR FAMILY AND MEDICAL LEAVE

Instructions: Page one must be completed by employees anticipating consecutive absences of ten or more days.
Original requests should be submitted to the PAYROLL DEPARTMENT two weeks prior to leave beginning date.
The physician does not complete page one of this form. Page 2 of this form must be complete by physician.

ALL NON-SHADED AREAS (WHITE AREAS) MUST BE COMPLETED

Name				Date	
	First	Middle	Last		
Address					
	Number and Street		City	State	Zip Code
Telephone Number	( )		Social Security Number		
School/Facility or Department			Position		

Please Check (✓) the Appropriate Box and Supply the Requested Dates

	I Am Requesting Family and Medical Leave		
		Beginning Date	Ending Date
	I Am Requesting My Previously Approved Family and Medical Leave Be Extended		
			Extended Ending Date

Signature of Employee	Date	Signature of Approving Supervisor	Date

Purpose of Leave

Please Check (✓) the Appropriate Box and Supply the Requested Information

	Personal Disability *		Birth of Child *
	Care of Family Member *		Adoption or Foster Care Placement **
Name of Family Member		Name of Child	
Relationship to Employee		Date of Placement	

**** Health Care Provider Must Complete Appropriate Certification on Reverse Side of Form Or Attach a Signed Physician's Statement Containing the Requested Information***

***** Attach Documentation of Adoption or Foster Care***

REVISED **JUNE 2018**

Instructions: A physician must complete and sign this page. OR
You may provide a written, signed physician's statement containing the information requested below.

CERTIFICATION OF HEALTH CARE PROVIDER

Name of Physician:

Street Address:

City and State: Zip Code:

Telephone Number: License Number:

Signature of Physician: Date:

PHYSICIAN MUST COMPLETE APPROPRIATE SECTION BELOW:

SECTION A: Complete for Employee Disability

Employee Name:

Date Disability Commenced: Probable Duration or Ending Date:

Describe the serious health condition that makes the employee unable to perform the essential functions of his/her employment.
Attach additional pages if necessary.

SECTION B: Complete for Birth of Child

Employee Name:

Expected Date of Delivery: Date of Disability: Beginning Ending

Comments:

SECTION C: Complete for Care of Family Member

Employee Name:

Name of Family Member:

Dates Employee's Presence Is Necessary for Care of Family Member: Beginning Ending

Describe the serious health condition of family member. Attach additional pages if necessary.

REVISED JUNE 2018