Hamilton Township School District
1876 Dr. Dennis Forman Drive
Mays Landing NJ, 08330
609-625-6600

FMLA/NJFLA FAMILY/MEDICAL LEAVE OF ABSENCE REQUEST FORM

Name: _____
Last First MI

Date of Hire: _____ Email: _____
Home Phone: _____

Department: _____
Supervisor: _____

Requested leave period:

Leave Begin Date: _____ Leave End Date: _____

Phone number where you can be reached while on leave:
_____

Please note that only the following events qualify for Federal (FMLA) or NJ State Law (NJFLA). If the leave request is not for one of these events, it will be handled as sick leave or a personal leave of absence request, as appropriate.

I am requesting a leave of absence for the following reason:

( ) The birth of child, or placement of a child in my home for adoption or childcare (including for school closure/childcare related to COVID-19)
( ) A serious health condition that makes me unable to perform the essential functions of my job
( ) A serious health condition affecting my ( ) spouse, ( ) child, ( ) parent, for which I am needed to provide care. (NJFLA definition of 'family' includes anyone with whom you have a 'family' relationship)
Please provide the name of the family member:
_____
Please attach the appropriate documentation (i.e., birth certificate, adoption certificate, foster care court order, letter of school / childcare facility closure due to COIVD-19). For a serious health condition, your health care provider must complete the appropriate Certification of Healthcare Provider Form.

Please indicate how you wish to use time balances (indicate specific amounts on lines provided):
( ) pay using **only earned time:** ____ sick, ____ vacation
( ) using all earned **and unearned time:** ____ sick, ____ vacation
( ) do not pay; maintain all time balances

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If requesting reduced hours or intermittent leave, please describe:
_____

Has a leave been approved for you within the last 12 or 24 months? ( ) Yes ( ) No

I understand that I am responsible for the cost of health and dental benefits while on leave without pay, and payment for benefits must be provided for ongoing coverage.
I further understand that any false information given to support this request for leave may result in disciplinary action up to and including termination of employment. I also understand that if my request for leave is denied, I may resubmit my request at any time.

Print Employee Name: _____
Employee Signature: _____ Date: _____

HR Use Only: This request for leave has been fully reviewed and documented.

Approved: _____ Denied: _____

Human Resources Signature: _____

Date: _____