MONONGALIA COUNTY SCHOOLS

MEDICAL/FMLA REQUEST FORM

EMPLOYEE INFORMATION

Last Name ______________________________ First Name ______________________________

Employee ID# __________________________ E-mail Address ___________________________

Home Address ____

City ______________________________ State _________ Zip Code _____________________

Phone number (____) __________________________

DEPARTMENT INFORMATION

School Name ___________________________ Position ________________________________

Reason for leave/Procedure date: ____

Approximate Dates of Leave:

Beginning _________________ Ending** ____________________ ◯ PAID ◯ UNPAID

Intermittent Leave ◯ YES ◯ NO
(Intermittent leave is not eligible for donated days)

Applied for Donated Days ◯ YES ◯ NO

What location would you like donated days requested from: _____________________________

***All requests must be accompanied by FMLA forms completed by your Doctor stating the need for and duration of leave.**
**If there is a change in your ending/return date, please contact the Mon.County HR office. 304-291-9210 ext.1501

SIGNATURES:

Employee ____________________________________ Date ______________________________

Monongalia HR Dept. ____________________________ Date ____________________________

FOR OFFICE USE ONLY

Date received by HR: [ ]

Board Approval Date: [ ]