THE SCHOOL DISTRICT OF PHILADELPHIA

Office of Talent
Employee Health Services
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Main office number: 215.400.4660
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CONTACT: fmla@philasd.org

FAMILY & MEDICAL LEAVE ACT (FMLA) COVER SHEET

Please return this completed form via email, fax, mail or drop off for FMLA eligibility verification.

I understand that to be eligible for protected leave under the Family & Medical Leave Act, I must have been employed by the School District of Philadelphia for a cumulative total of **12 months** AND have physically worked a minimum of **1250 hours** during the 12 months before the FMLA beginning date.

____ ______________________

NAME ***EMPLOYEE ID#***

____

STREET ADDRESS

____

CITY, STATE, ZIP CODE

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Telephone # (Cell or Home) ____

Position: ______________________ **Work Location:** ______________________
(SCHOOL OR OFFICE)

Beginning date for FMLA protection: ______________________
**This date should match the first date you were absent or will be absent for the type of leave you will take.*

Type of leave you are requesting FMLA protection for:

______Personal illness

______Illness in family **Relationship of family member to you:*______________________ **Age (if child):*__________

______The birth of your child ______Adoption/foster care placement**

______Serious injury or illness of Servicemember** ______Qualifying Military Exigency (unpaid leave)** ______Military Caregiver**

***These FMLA requests have specific certification forms that you will receive if you meet the FMLA eligibility requirements.*

How will you take your leave? :

____ consecutively (an absence of more than 3 consecutive work days)

____ intermittently (non-consecutive absences)

***If your consecutive leave will last for **less than 12 weeks**, your FMLA request will be processed for intermittent leave.*

_____ **Check if you want your FMLA notification letters sent to your SDP email address**

EMAIL ADDRESS:______________________________________

OR

_____ **Check if you want your FMLA notification letters mailed to your home**

DATE CERT REQ'D/ REC'D
____
NEW FMLA YR _____
RE-CERT _____
FOR OFFICE USE ONLY