Fairfax County PUBLIC SCHOOLS
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Request for a Foreseeable Family Medical Leave Form A

Date Received by Disability and Leaves: _____

This form is used to request leave under the Family and Medical Leave Act (FMLA). Please submit completed form to the Department of Human Resources, Disability and Leaves Section **at least 30 days in advance** of the requested date for starting absence. **Completed forms should be sent via email to DisabilityandLeaves@fcps.edu or via fax 571-423-5013.** Include appropriate Certification of Health Care Provider form when the request is based on a serious personal health condition, the birth, adoption, or foster care placement of a child, or the care of a family member or a covered servicemember. Include Certification of Qualifying Exigency form for an absence due to a qualifying exigency. **You must report your leave in MyTime using leave code "Sick-FMLA".** More information about FMLA may be found on the FCPS website (www.fcps.edu, search "FMLA").

SECTION I: To be Completed by the EMPLOYEE

Your Name (Last, First, Middle) _____ Date of Request _____

Your Home Address (street and apt. number) _____ City _____ State _____ Zip Code _____

Employee ID Number _____ Personal Email Address _____ Home Phone Number _____

Work Location _____ Region _____ Work Phone Number _____

Position _____

☐ Full-time

☐ Part-time (specify): _____

1. Dates of Leave Requested:

Beginning Date of Absence *(month/day/year):* _____ Date Sick Leave Begins *(month/day/year):* _____

Date Leave Without Pay Begins *(month/day/year):* _____ Expected Return Date *(month/day/year):* _____
(A maximum of 12 weeks per 12-month period from the beginning date of leave may be requested.)

2. Application of Leave (check one (1) and explain):

☐ Continuous
☐ Reduced Schedule
☐ Intermittent

3. Reason for Leave Request (check one (1) below):

☐ Serious Personal Health Condition
Must also complete Form D (HR-146).

☐ Care of a Family Member due to a Serious Health Condition (select one):
- ☐ Spouse
- ☐ Child
- ☐ Parent

Must also complete Form E (HR-147).

☐ Birth or adoption of a child or placement of a foster child
Additional documentation may be needed.

☐ Care of an injured or ill active servicemember
Must also complete Form F (HR-148).

☐ Management of exigencies
Must also complete Form G (HR-149).

Explanation of the care to be provided and an estimate of the time period required, including a schedule, if leave is to be taken intermittently or on a reduced leave schedule:

_____

_____

_____

I acknowledge the contact information above is accurate. I will ensure FCPS is notified if any information changes. I have read **Regulation 4835**, and I understand that I may or may not meet the FMLA eligibility requirements.

☐ I have sent the required supporting documentation to the Disability and Leaves Section as indicated above.
Please note: You have 15 calendar days from the date of this request to provide the certification and/or supporting documentation to the Disability and Leaves Section. Not providing the information within the required time may result in the request being denied.

Employee Signature: _____ Date: _____

SECTION II: To be Completed by the PRINCIPAL or PROGRAM MANAGER

☐ I am aware of the above employee's FMLA request. My signature does not indicate a request approval or denial. Official determination will be made by the Disability and Leaves Section.

Principal or Program Manager Signature: _____ Date: _____

The above employee's leave of absence request is: ☐ Approved ☐ Denied

Department of Human Resources, Disability and Leaves Section: _____ Date: _____