Rev. Effective May 1, 2009

NORTH CAROLINA DEPARTMENT OF PUBLIC INSTRUCTION
Application for Family and Medical Leave

Employee Name: _____ BEACON Personnel #: _____

Address/Phone During Absence: _____

Area/Division/Section: _____

Reason for the Leave Request:

_____ Birth of child; anticipated birth date: _____
_____ Adoption of child/foster care; anticipated adoption/foster care date: _____
_____ To care for a child, spouse, or parent with a serious health condition
_____ Serious health condition of employee
_____ Exigency Leave
_____ Military Caregiver Leave

Leave Request Dates: From _____ to _____

Indicate below if you wish to use leave to cover your absence:
(Family and Medical Leave is unpaid leave for an absence of up to twelve weeks. The employee may receive income during this period by exhausting available sick, vacation, and bonus leave.)

_____ Vacation/Bonus leave; number of hours (for each) _____
_____ Sick* leave; number of hours _____
*For the employeeôs illness, the employee shall exhaust available sick leave and may choose to exhaust available vacation, or any portion, before going on leave without pay.

Certification:
Certification of leave taken for the adoption of a child may be supported by reasonable proof of adoption. Certification of leave taken for the birth of a child, illness of employeeôs spouse, child, or parent, or an employee illness shall be in the form of a **physician's statement** indicating the date of onset and medical condition requiring leave.
Certification for exigency leave will be copy of military memberôs federal active duty orders for contingency operation and information related to a specific exigency activity. Certification for Military Caregiver leave will be a health care providerôs statement or Department of Defense representative statement.

Physician's statement must be mailed directly to:	**Human Resources Director** **N. C. Dept. of Public Instruction** **301 N. Wilmington St.** **Raleigh, N. C. 27601-2825**

Applicant:
If I fail to return to work after the period of leave to which I am entitled has expired for a reason other than the continuation, recurrence, or onset of a serious health condition or other circumstances beyond my control, I will be required to repay insurance premiums paid by the State.

_____ _____
Signature of Applicant Date

Signature acknowledging receipt of FMLA request:

_____ _____
Signature of Supervisor Date

_____ _____
Signature of Division Director Date

Approval of FMLA request:

Instructions: Employee completes form, acquires appropriate signatures, and submits to Human Resources Director for final approval.

_____	_____
Signature of Human Resources Director	Date

Instructions: Employee completes form, acquires appropriate signatures, and submits to Human Resources Director for final approval.