



APPLICATION FOR FAMILY AND MEDICAL LEAVE

Please return form to Hope-King Randall in Human Resources

Phone: 843-488-6559

Fax: 843-488-7754

Email: hrrandall@horrycountyschools.net

Employee Name: _____ Date of Application: _____

Employee ID: _____

Position: _____ Principal/Supervisor: _____

School/Department: _____

Employee Address: _____

Employee Phone Number: _____

Start Date of Leave: _____ Expected Date of Return to Work: _____

Reason for Leave:

NOTICE - Please initial each of the following:

_____ An employee requesting leave for a serious health condition or the serious health condition of the employee's spouse, child or parent must submit the attached medical certification statement from a physician within 15 days of application for leave. Prescription pad notes will not be accepted.

_____ I hereby authorize a health care provider representing Horry County Schools to contact my physician to verify the reason for my requested family and medical leave.

_____ I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Horry County Schools.

Employee Signature: _____ Date: _____

Principal/Supervisor Signature: _____ Date: _____

FMLA Leave Approved By:

HR Signature: _____ Date: _____