LABBB
Collaborative Programs
Since 1974

FMLA REQUEST FORM

Employee Name (printed) _____

Program _____

Date Submitting This Form _____

I am notifying the LABBB Collaborative of my need to take family/medical leave due to:

1.) ___ The birth of a child, or the placement of a child with me for adoption or foster care; or

2.) ___ A serious health condition that makes me unable to perform the essential functions of my job; or

3.) ___ A serious health condition affecting my ___ spouse, ___ child, ___ parent, for which I am needed to provide care.

I am notifying you that this leave will begin on _____ (date) and that I expect

leave to continue until, on or about _____ (date).

1a.) ___ If my maternity/medical leave extends beyond eight consecutive weeks I understand that I will be required to provide a doctor's note stating the specific date I can return to work.

1b.) ___ I would like to apply _____ of my accumulated sick days towards my maternity/medical leave.

I understand that failure to return to work at the end of the leave period (12 weeks) may be treated as a resignation unless an extension of leave has been agreed upon and approved by the employer.

_____

Employee Signature Date

_____

Executive Director Signature Date

Central Office • *123 Cambridge Street • Burlington, MA 01803 • Tel:339-222-5615 • fax: 781-998-4654*
Pre-school, Elementary & Middle School Programs • *123 Cambridge Street • Burlington, MA 01803 • Tel:339-900-2629 • fax: 781-998-4654*
High School Programs • *251 Waltham Street • Lexington, MA 02421 • Tel:781-861-2400 • fax: 781-861-1351*
www.labbb.com