Patric Barbieri
Executive Director

Maria Giangrande
Administrative Assistant

***Donna Goodell**, Program Director*
Pre-school, Elementary & Middle School Programs

***James Kelly**, Program Director*
High School Programs

LABBB COLLABORATIVE
FMLA LEAVE 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 disability 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 disability/maternity leave.

Employee Signature____

____

Executive Director Signature **Date**