

*William H. Lupini*  
Interim Executive Director

*Joseph Adams*  
Director of Finance & Operations



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

*James Kelly, Program Director*  
High School Programs

## 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