MADISON DISTRICT PUBLIC SCHOOLS

Prepare. Aspire. **Succeed.**

Extended Leave Request Form

Required for absences that exceed three consecutive business days

Employee Name: _____ Work Location: _____

Please indicate one of the following reasons for extended leave:

- ☐ Maternity - Due Date _____
- ☐ Medical for Family Member
- ☐ Intermittent
- ☐ COVID-19
  Was this a workplace exposure (yes/no) _____
- ☐ Medical for Self
- ☐ Paternity
- ☐ Other (Please Explain)_____

Leave Information:

Requested last day of work: _____
Expected return to work date: _____
Total anticipated leave (in days): _____
Number of PTO days to be used: _____

Paid Time Off (PTO)

PTO will be verified at the time of actual leave.

Insurance Premiums

Any employee that misses a pay during their leave will need to submit a check with their portion of the insurance premiums to the district to maintain their benefit coverage. Checks should be made out to *Madison District Public Schools* and mailed to:

Administration Building Attn: Benefits
26550 John R Rd
Madison Heights, MI 48071

Acknowledgement

This form serves as an acknowledgement of a request for leave. Medical certification is required for all medical leaves. You will be notified regarding your qualification for Family Medical Leave Act (FMLA).

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Please return a copy of this form 30 days prior to the start of your leave to your Benefit Manager at the Adminstration Office.