MONONGALIA COUNTY SCHOOLS

MEDICAL/FMLA REQUEST FORM

EMPLOYEE INFORMATION

Last Name _____ First Name _____

Employee ID# _____ E-mail Address _____

Home Address _____

City _____ State _____ Zip Code _____

Phone number (___) _____

DEPARTMENT INFORMATION

School Name _____ Position _____

Reason for leave/Procedure date: _____

Approximate Dates of Leave:

Beginning _____ Ending** _____ ⬭ PAID ⬭ UNPAID

Intermittent Leave ⬭ YES ⬭ NO
(Intermittent leave is not eligible for donated days)

Applied for Donated Days ⬭ YES ⬭ NO

What location would you like donated days requested from: _____

***All requests must be accompanied by FMLA forms completed by your Doctor stating the need for and duration of leave.**

**If there is a change in your ending/return date, please contact the Mon.County HR office. 304-291-9210 ext.1501

SIGNATURES:

Employee _____ Date _____

Monongalia HR Dept. _____ Date _____

FOR OFFICE USE ONLY

Date received by HR: ☐

Board Approval Date: ☐