Application for Family Medical Leave for Workers' Compensation

Name: _____ Teams ID: _____

Campus: _____ Assignment: _____

Current Address: _____

Start Date of Anticipated Leave: _____ Expected Date of Return to Work: _____

Reason for Leave (Explain): _____

_____

Note: An employee requesting leave for the employee's health serious condition due to a compensable work related injury, must submit a verifying medical certification from the Workers' Compensation physician. **(Texas Workers' Compensation Work Status Report (DWC – 73) is acceptable as verification of a serious health condition.)**

I authorize a representative of Carrollton-Farmers Branch ISD to contact my health-care provider to verify the authenticity of the medical certification for my requested Family Medical Leave.

I understand that a failure to return to work at the end of my leave period may be treated as absent without leave, and may result in further disciplinary action up to and including termination of employment, unless additional leave, pursuant to Board Policies DEC (Legal) and DEC (Local) has been agreed upon and approved in writing.

Signature: _____ Date: _____

I prefer communication be submitted to me via ☐U.S. Mail or ☐district e-mail.

Received by:

Supervisor/Principal: _____ Date: _____

Benefits Department: _____ Date: _____