



HUMAN RESOURCES

3755 Church Street
Zachary, LA 70791
225.658.4969
Fax 225.658.5261
www.zacharyschools.org

Application for Family or Medical Leave

Name: _____ Department: _____

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 serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician within 15 days of application for leave.

I hereby authorize a health care provider representing Zachary Community School Board to contact my physician to verify the reason for my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as resignation unless an extension has been agreed upon and approved in writing by Zachary Community School Board.

Signature: _____ Date: _____

APPROVED BY:

Supervisor

Director of Human Resources