



WEST BRANCH AREA SCHOOL DISTRICT Family Medical Leave Request

Name: _____ Date: _____

Position: _____

Date(s) requested for leave: _____

Reason for leave: _____

Have you worked in the District for one year? _____

If Professional Employee, will leave be during the last five weeks of the semester? _____

Doctors excuse: Yes _____ No _____

Will all sick, vacation, and personal days be used?: Yes _____ No _____

If yes, how many of each have been accumulated? (to be completed by business manager or bookkeeper)

Sick _____ Vacation _____ Personal _____

Will a sub be needed: _____

Signature of Immediate Supervisor Date: _____

Received by School Board Secretary Date: _____

Signature of Business Manager Date: _____

Signature of Superintendent Date: _____

Signature of Bookkeeper (to keep on file) Date: _____