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 a sub be needed:_____

_____ Date:_____
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)