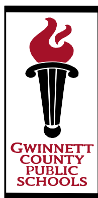

Human Resources

Intermittent FMLA Request Form

Benefit & Leave Administration • 437 Old Peachtree Road, NW, Suwanee GA 30024-2978
Fax: 678.301.6111 • Email: Leave@gcpsk12.org

Intermittent Leave is leave that is less than ten full consecutive days

Name ________________ (First) ________________ (Last) Employee ID # ________________ (**NOT** Social Security Number) Position ________________

Street Address ________________ City ________________ State ______ ZIP ________

Contact Number ________________ Personal E-mail Address ________________ GCPS Location ________

Estimated Leave Begin Date ________________

Expected Leave Schedule / Duration: ____

____

Intermittent FMLA

- ○ **Personal Illness**
- ○ **Maternity** - Due date ____________
- ○ **Adoption** - Estimated adoption date ____________
- ○ **Worker's Compensation**
- ○ **Care of newborn/adoption**
- ○ **Military**
- ○ **Illness of a family member**
  - ○ Spouse ○ Child ○ Parent

Maternity and Adoption Intermittent leave must be used within one year of the birth/adoption.

Additional Information

- Do you want to use accrued leave: Yes ○ No ○
- Sick Leave Bank member: Yes ○ No ○
- Do you have a spouse that works for Gwinnett County Public Schools? Yes ○ No ○
- If so, provide name of spouse: ________________ Employee ID # ________________
- Is your spouse a Sick Leave Bank member: Yes ○ No ○
- Comments: ____

Signature and Certification

Failure to follow leave guidelines may result in loss of all rights and privileges provided under current policy. If request is found to be fraudulent or documentation does not support your request, your approval may be revoked. Any changes of your leave must be communicated in writing to the Benefits & Leave Administration Office. If you qualify for the Family Medical Leave Act (FMLA) and your leave request is for a qualified reason, the district will use a rolling 12-month period measured backward from the date you use FMLA leave (each time you take FMLA leave, the remaining leave is the balance of the 60 working days not used during the immediately preceding 12 months).

I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT.

Employee's Signature: ________________________________ **Date:** ________________

Please submit this form and all supporting documentation to the Benefits & Leave Administration Office within ten calendar days of the request.

----------------------------To be completed by Human Resources Leave Administration Office----------------------------

FMLA eligible? YES / NO Previous FMLA used ____________ FMLA begins ____________ FMLA ends ____________

Comments: ____

Beginning Date of Intermittent FMLA ________________ Leave schedule / duration / period of time: ________________

Leave Administration Signature: ________________________________ Date: ________________