EXHIBIT E

EMPLOYEE REQUEST FOR FORESEEABLE FAMILY AND MEDICAL LEAVE

Type or Print:

| 1.Name of Employee (First Name, Middle Initial, Last Name) | 2. Employee's Position |
|---|---|

3. Reason for requested leave,

   a.☐ Birth of son or daughter of the employee and to care for such son or daughter.

   b.☐ Placement of a son or daughter with employee for adoption of foster care.

   c.☐ To care for spouse, child, or parent with a serious health condition.

   d.☐ Because of employee's own serious health condition that makes him or her unable to perform job functions.

| 4. If "C" please check one:<br>☐ Spouse ☐ Child ☐ Parent | 5. If "C" state name and address of relation.<br>______________________________<br>______________________________ |
|---|---|
| 6. Date on which you wish to commence leave. | 7. Date of anticipated to return to work. |
| 8. Are you requesting leave on an intermittent or reduced leave schedule?<br>☐ yes ☐ No | 9. If "yes" please give schedule of when you anticipate you will be unavailable for work |

An employee seeking leave because of reason "3(d) above must provide medical certification within 15 days of as soon as practicable,

An employee seeking to return to work after a leave because of his or her own serious illness [reason "3 (D)] also must provide a medical certification of ability to perform job duties before being allowed to resume work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of my leave period, I will reimburse the District for the cost of my health benefit provided during my leave, unless I fail to return to work because of continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expires. I understand that I may not be permitted to resume my position with the District until I provide medical certification as appropriate.

Signed: Dated:

**I understand that typing my name above is the same as signing by hand agreeing to the above terms.**

**Certification of Health Care Provider for Employee's Serious Health Condition**
**(Family and Medical Leave Act)**