



EXTENDED LEAVE OF ABSENCE REQUEST FORM

Employee Name: _____ Date of Request: _____

Employee Position: _____ Employee Location: _____

Date leave is to begin: _____ Expected return date: _____

If the leave is to be intermittent or on a reduced schedule, please indicate the schedule and duration of the leave.

Reason for leave:

Personal Sabbatical Family Other, Please Explain: (May attached letter)

FMLA

- Birth of child.
- Care of a new born or placement of a child in your adoption or foster care.
- Military
- Serious health condition of spouse, child or parent.
- Serious health condition of employee.

If the requested leave is to care for a seriously ill family member, please indicate the name of the person to be cared for and their relationship to you.

Name: _____ Relationship: _____

Leave for the care of a seriously ill family member or for the employee's own illness will require completion of a Certification Form by the health care provider of the serious ill person.

Employees who take leave for their own serious health condition will be required to provide certification from their health care provider that the employee is to return to work, prior to the time the employee is reinstated.

The following information is required for this process:

Employee's Signature: _____ Date: _____

APPROVED _____ DATE _____
Administrator/Supervisor

APPROVED _____ DATE _____
Superintendent

APPROVED _____ DATE _____
Human Resources Office

For Human Resources Department use only

- Leave is approved.
- Leave is approved contingent upon the following: _____
- Leave is denied. Reason: _____

The following accrued time will be utilized to ensure compensation continuance.

_____ Sick Hours _____ Vacation Hours _____ Personal Hours

Misc. Notes: _____

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