Leave of Absence Request

(For Absences 5 or More Days)

CONFIDENTIAL & TIME SENSITIVE

PLEASE COMPLETE THIS FORM AND RETURN TO THE BENEFITS SPECIALIST AT CENTRAL OFFICE 30 DAYS IN ADVANCE OF LEAVE IF POSSIBLE.

EMPLOYEE INFORMATION

Employee Name:	**Employee #:**	**Date:**
Work Location:	**Position:**	
Telephone Number: ☐ HOME ☐ CELL		

ABSENCE INFORMATION

☐ **With Pay** ☐ **Without Pay**

Absence Start Date:	**Anticipated Last Day Absent:** ***(Doctor's Disability Release Form must be on file prior to return to work)***

Name of Substitute (if available):

TYPE OF LEAVE

☐ **Leave of Absence > 5 Days** ☐ **Intermittent Absence*** *(Please note additional information required below)*

**** For Intermittent Absences, describe your intermittent or reduced work schedule (e.g., "up to 2-3 sick days a month per doctor"). Intermittent absences must be medically necessary and documented in a current "Certification of Health Care Provider…".***

REASON(S) FOR LEAVE

Please indicate the applicable reason(s) for your leave below.

- ☐ Employee's Own Medical or Sick Leave
- ☐ Personal or Medical Leave for Immediate Family
- ☐ Childbearing Leave
- ☐ Child-Rearing Leave *(Leave Without Pay)*
- ☐ Military Leave
- ☐ Other – Please Specify:_____

EMPLOYEE SIGNATURE:

Employee:	*Date*:

APPROVALS:

Building Principal/Supervisor:	*Date:*
Human Resources:	*Date:*

For Office Use Only:

Accrual Balances:
Sick:
Personal:
Vacation: