



# Request for Leave of Absence

*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

<b>Employee Name:</b>	<b>Date:</b>
<b>Work Location:</b>	<b>Position:</b>
<b>Telephone Number:</b> <input type="checkbox"/> HOME <input type="checkbox"/> CELL	

## ABSENCE INFORMATION

<input type="checkbox"/> <b>With Pay</b>	<input type="checkbox"/> <b>Without Pay</b>
<b>Absence Start Date:</b>	<b>Anticipated Last Day Absent:</b> <small><i>(Doctor's Disability Release Form <u>must</u> be on file prior to return to work)</i></small>
<b>Name of Substitute (if available):</b>	

## TYPE OF LEAVE

<input type="checkbox"/> <b>Leave of Absence &gt; 5 Days</b>	<input type="checkbox"/> <b>Intermittent Absence</b> <small><i>(see required information below)</i></small>
<small><i>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..."</i></small>	

## 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
- Short-Term Maternity Leave
- Child-Rearing Leave *(Leave Without Pay)*
- Paternity Leave
- Military Leave
- Other – Please Specify: \_\_\_\_\_

## EMPLOYEE SIGNATURE:

<i>Employee:</i>	<i>Date:</i>
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## APPROVALS:

<i>Building Principal/Supervisor:</i>	<i>Date:</i>
<i>Human Resources:</i>	<i>Date:</i>

<b>For Office Use Only:</b>
<small>Accruals at Start of Leave of Absence:</small>
<small>Sick:</small>
<small>Personal:</small>
<small>Vacation:</small>