



Leave of Absence Request

This form is to be used by all employees to request medical leave (including pregnancy disability leave ("PDL")) exceeding ten days. This request should be forwarded to Human Resources at least three weeks before the requested leave is to start.

Print Name _____ Telephone No. _____

Address _____

School Site _____ Position _____ Hours/Day _____

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Reason for Leave:

<input type="checkbox"/> Catastrophic Leave <input type="checkbox"/> Paternity Leave <input type="checkbox"/> Military Leave	From ___/___/___ through ___/___/___
<input type="checkbox"/> Personal Illness <input type="checkbox"/> Family Illness <i>Requires Certification from a Health Care Provider</i>	From ___/___/___ through ___/___/___ Intermittently: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Family Member _____ Relation _____
<input type="checkbox"/> Personal Necessity Leave Explanation _____	From ___/___/___ through ___/___/___ Intermittently: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Maternity Leave/Maternity Related Leave <i>Requires Certification from a Health Care Provider</i> <input type="checkbox"/> Natural Birth <input type="checkbox"/> Cesarean Birth	Estimated Due Date ___/___/___ <input type="checkbox"/> I authorize use of my applicable accrued leave balance From ___/___/___ through ___/___/___
<input type="checkbox"/> CFRA (child bonding)	From ___/___/___ through ___/___/___
<input type="checkbox"/> Unpaid Leave Explanation _____	From ___/___/___ through ___/___/___

Employee Signature

Date

Human Resources Director/Designee

Date