



LEAVE REQUEST FORM

Family and Medical Leave Act ("FMLA")
California Family Rights Act ("CFRA")
Pregnancy Disability Leave ("PDL")

Employee Name: _____ Date of Hire: _____
Home Address: _____ Position: _____
Phone Number: _____ Site: _____
Personal Email: _____ Is it ok to send emails to this address?
Date of Request: _____ Yes No

BASIS FOR FAMILY MEDICAL LEAVE OR PREGNANCY DISABILITY LEAVE

I'm providing the School with written notification of my need to take family medical leave due to:

- The birth of a child, or the placement of a child with me for adoption or foster care
- A serious health condition (may include disability resulting from pregnancy) that makes me unable to perform the essential functions of my job
- A serious health condition affecting my spouse, child, parent, for which I am needed to provide care. Family Member: _____
- To care for a "covered service member" or an "active service member," allowable under the provisions of the law
- The extension of FMLA, CFRA or PDL previously approved:
Dates prior approved are: _____ to _____

DATES ANTICIPATED/REQUIRED FOR LEAVE

I expect this leave to begin on or about _____ and end on or about _____.
(Date) (Date)

REQUIRED MEDICAL CERTIFICATION

FOR FMLA/CFRA/PDL LEAVES I understand that in order for my leave to be approved, I must provide a medical certification to the School prior to my leave addressing 1) the date the serious health condition began; 2) the duration of the condition; and 3) a statement that I am unable to work due to a serious health condition, or that a serious health condition of a family member warrants my absence from work.

INTENT TO RETURN

I do do not intend to return to my position at the school after the end of my leave.

PAYMENT

I understand that this is an unpaid leave of absence. If I would like to be paid for any portion of the leave I understand that I need to use my sick/personal time (please attach an Employee Absence Request for any days you wish to use your sick/personal time).

EMPLOYEE REQUEST ADDITIONAL ACKNOWLEDGEMENTS:

- I understand my continuing obligation to pay my share of all health insurance premiums in a timely manner during the leave, unless I decline to continue my coverage during my leave by submitting a written waiver. I further understand that my failure to return to work after my leave may result in the School's enforcement of its legal right to recover from me costs of health insurance premium payments paid by the School during my leave.
- I acknowledge that, under FMLA/CFRA/PDL, I will be reinstated, upon return from an approved leave herein, to the same or an equivalent position, subject to applicable law.
- I acknowledge that I have carefully read this request and the applicable sections of the Employee Handbook and understand and agree with the provisions therein.

(Date)

(Employee Signature)

(Date)

(Supervisor/Principal's Acknowledgement)

To Be Completed By Employer

The request leave is approved to begin on _____ and end on _____
(Date) (Date)

Additional Comments: _____

(Date)

(HR Coordinator)

Copy of approval/denial letter to:

- Supervisor
- Payroll Changes
- Medical File
- Entered on LOA Spreadsheet
- Entered in QSS