



FOR HUMAN RESOURCES USE ONLY:

Leave Type: _____ FMLA Ends: _____

Employee Classification (select one): A M P

Medical Certification included: Yes No N/A

LEAVE OF ABSENCE REQUEST

**Directions: Type or print the required information.
THE MEDICAL CERTIFICATION MUST ACCOMPANY THIS FORM**

1. EMPLOYEE NAME (First Name, Middle Initial, Last Name)		2. EMPLOYEE JOB TITLE	
3. EMPLOYEE ID NUMBER	4. CAMPUS/DEPARTMENT	5. WORK SCHEDULE S M T W Th F S	
6. REASON FOR REQUESTED LEAVE: a. <input type="checkbox"/> Birth of a son or daughter of the employee and in order to care for such son or daughter after birth. <i>(Attach birth certificate if requesting parental leave)</i> b. <input type="checkbox"/> Placement of a son or daughter with employee for adoption or foster care. <i>(Attach a copy of legal documentation)</i> c. <input type="checkbox"/> In order to care for spouse, child, or parent with a serious health condition. d. <input type="checkbox"/> Because of employee's own serious health condition that makes him/her unable to perform job function. e. <input type="checkbox"/> Military Leave <i>(Attach a copy of military orders)</i>			
7. IF "C", PLEASE CHECK ONE: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent		8. IF "C", STATE NAME AND ATTACH MEDICAL CERTIFICATION.	
9. REQUESTED START DATE: ____/____/____	LAST DAY TO WORK: ____/____/____	10. ANTICIPATED RETURN DATE: ____/____/____ OR UNKNOWN <i>(select one only)</i>	
11. ARE YOU REQUESTING LEAVE ON A FULL-TIME OR INTERMITTENT BASIS? _____ Full-Time _____ Intermittent		12. IF "INTERMITTENT", PLEASE GIVE SCHEDULE OF WHEN YOU ANTICIPATE YOU WILL BE UNAVAILABLE FOR WORK. (APPLIES ONLY IF ELIGIBLE FOR FML) _____	

Employees seeking leave because of reason 6(a), 6(c), or 6(d) above, **must provide medical certification within 15 days** or as soon as practicable. Employees seeking to return to work after a leave because of birth of a son or daughter or their own serious illness must also provide the Human Resources Department a fitness for duty certification of ability to perform essential functions before they are authorized by the Human Resources Department to return to work.

I hereby agree that while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the District for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired or that I am needed to care for my spouse if he/she has a serious health condition on the date that my leave expired. I understand that I may not be permitted to resume my position with the District until I provide medical certification, as appropriate.

THE MEDICAL CERTIFICATION MUST ACCOMPANY THIS FORM

EMPLOYEE AND SUPERVISOR SIGNATURES

Employee Signature

Principal/Supervisor Signature

Date

Date