

MINOOKA CCSD #201

REQUEST FOR LEAVE OF ABSENCE

**(PLEASE COMPLETE AND RETURN TO THE BUSINESS OFFICE)**

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| **Name:**       | **Current Date:** Click here to enter a date. |
| **Building:**       | **Hire Date:** Click here to enter a date. |
|  |
| **Job Status:**  [ ]  **Licensed Staff** [ ]  **Non Certified Staff** |
| Have you utilized FMLA time in the past 12 months? | [ ] **Yes** [ ] **No**If yes, when?       |
| Do you have a stipend that will be effected by this leave? | [ ] **Yes** [ ] **No**If yes, what?       |

**Type of leave requested:**

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| **FMLA leave\*** *(Maximum of 12 weeks in a “rolling” 12 month period)* |
|[ ]  Medical – *Self/Family Member* ***(Medical Certification Required)*** |
|[ ]  Parental – *Maternity/Paternity* |
|[ ]  Military |
|  |
|[ ]  **Leave of Absence – Unpaid** *(Approval granted by the Superintendent’s Office)* |
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| **Leave of Absence – NOT FMLA Eligible** |
|[ ]  Medical – *Self/Family Member* ***(Medical Certification Required)*** |
|[ ]  Parental – *Maternity/Paternity* |
|[ ]  Military |

**Length of leave:**

|  |  |  |
| --- | --- | --- |
| Start Date:  | End Date: | Return Date:  |
| Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
| ***\*For FMLA Leave Requests:*** *Insurance continues for the duration of the 12 week family and medical leave period at the same level and under the same conditions that existed at the time of the commencement of the leave. Any leave over 12 weeks will require further approval by the Board of Education. The employee’s group health insurance may be continued after 12 weeks, but be at the full expense of the eligible employee.* |

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| **Will you utilize sick, personal or vacation days as part of your leave?** | [ ] Yes [ ] No |

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| --- | --- | --- | --- |
| If yes, how many? | **Sick -**   | **Personal -**  | **Vacation -**  |
|  |       |  |  |
| ***\*NOTE – Current school year allotment maybe subject to proration\**** |
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