Lamoille North Supervisory Union Request for Leave
Please print in ink.

Name: _____ Date:_____ Department/School: _____

Employee Type:
☐ Teacher
☐ Support Staff
☐ Administrator

Status:
☐ Full Time
☐ Part Time

Is a substitute needed? ☐ Yes ☐ No

NOTE: LEAVE TIME IS REPORTED IN HOURS.

I am requesting a paid leave starting on (date/time): _____and I expect to return on or about (date):_____for a total of _____**/hours**, for the purpose of (Please *check the appropriate box below according to your job category.):*

Teachers	Administrators	Support Staff
❑ Sick Leave	❑ Sick Leave	❑ Sick Leave
❑ Personal Leave	❑ Personal Leave	❑ Personal Leave
❑ Bereavement	❑ Bereavement	❑ Bereavement
❑ Professional Leave	❑ Professional Leave	❑ Professional Leave
❑ Emergency Leave** (reason required)	❑ Family Medical Leave (FMLA)*	❑ Emergency Leave** (reason required)
❑ Family Medical Leave (FMLA)*	❑ Leave of Absence	❑ Family Medical Leave (FMLA)*
❑ Leave of Absence	❑ Military Leave	❑ Leave of Absence
❑ Military Leave	❑ Jury Duty Leave	❑ Military Leave
❑ Jury Duty Leave	❑ Vacation	❑ Jury Duty Leave
❑ Other_____	❑ Other_____	❑ Vacation
		❑ Other_____

***For FMLA leave requests only, see reverse side.**

Important Information Concerning All Leaves

I understand that:

1) I am responsible for reading and understanding my master agreement, my individual contract, and policies regarding my leave benefits.
2) Any leave time beyond my contractual or agreed benefits will be unpaid, unless specifically granted by the Superintendent or his/her designee. Special permission for leave extensions may be required.
3) If granted a leave without pay, I may be responsible for paying 100% of the full monthly premium for any employee/dependent insurance for which I am enrolled.
4) I understand that while on a leave without pay, other than FMLA or contractual obligations of the Board, return to full employment may not always be possible and employment will always be subject to business conditions and contractual obligations if any exist.
5) If I do not return to work at the end of the approved leave or extension, my employment may be terminated.
6) Denied requests will be communicated to the individual prior to the requested leave date if forms are properly submitted.

Approvals

The following signature by the Employee indicates agreement to the terms of leave defined above:

Employee Signature: _____ Date: _____

The following signature from the Supervisor indicates that the time requested has been verified and is available:

Supervisor/Principal Signature: _____ Date: _____

****Superintendent /Designee Signature: _____ Date:_____**
**All Emergency Leave requests require the Superintendent's approval.

___ **Leave Approved** ____ **Leave Denied** ____ **Leave Unpaid**

Revised 1/13/17

Family Medical Leave

The Family Medical Leave Act is a federal law that entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons such as:

- Incapacity due to pregnancy, prenatal medical care or childbirth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Additionally, eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying situations. Qualifying situations may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. The FMLA also allows eligible employees to take up to 26 weeks of job-protected leave in a "single 12-month period" to care for a covered service member with a serious injury or illness.

Employees are eligible for FMLA if they have worked within the LNSU for at least one year and for at least 1,250 hours over the previous 12 months.

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to disrupt the employer's operations.

Employees may choose to use accrued paid leave while taking FMLA leave. The use of paid leave benefits such as sick leave will run concurrently with FMLA benefits.

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

After completing this initial form, you will be informed of your eligibility for leave and your rights and responsibilities under the FMLA. You may be asked to provide additional information to accurately determine, if the leave may qualify for FMLA protection, including the anticipated timing and duration of the leave, medical certification, or the circumstances supporting the need for military leave.

Please read the following information carefully. Your signature indicates your understanding that:

1) If I am granted a Family Medical Leave (FML) and I do not return to work, the district in which I work has the right to recover health premiums and related employer costs beyond my contractual benefits.
2) It may not be possible for the district to guarantee the same position upon my return from leave and I may be placed in an equivalent position with the same rate of pay, benefits and level of responsibility.
3) If I do not return to work at the end of the approved leave, I may be terminated from employment.
4) **Before** returning from a FMLA approved leave to care for my own serious health condition (including the birth of a child) I will be required to provide documentation signed by my health care provider certifying my fitness to return to work.

Employee Signature: _____ Date: _____

Please contact the LNSU Benefits Coordinator at (802) 851-1172 with any questions regarding Family Medical Leave.