Office of Human Resources
Request for Leave of Absence

ROCHESTER COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

Employees are required to notify HR if they will be absent for more than four full consecutive days in order for a determination to be made as to whether the absence qualifies under the FMLA

Section 1: PERSONAL INFORMATION (Staff Member completes Sections 1 and 2 and returns completed form to HR/Benefits Specialist)

Last Name:	**First Name:**	**DEN:**
Home Address:	**Work Phone:**	**Building/Department:**
Date Submitted:	**Phone:**	**Job Title:**
Signature:		

It is the employee's responsibility to notify their building principal and/or manager of expected leave of absence. For a long term leave of absence the employee will be responsible for securing a substitute and notifying HR.

Section 2: STAFF MEMBER: Check the type of leave and provide documentation as indicated

I request that my leave begin on _____ and end on _____
(If necessary, give approximate dates; a due date may be used for maternity leave of absences.)

	Family Medical Leaves (required medical certifications must be returned within 15 days of receipt)	
□	**Employee Illness**	**Certificate of Health Care Provider (Form WH-380-E)**
□	**Child/Parent/Spouse Illness**	**Certificate of Health Care Provider for Family Member's Illness/Injury (Form WH-380-F)**
□	**Maternity**	**Certificate of Health Care Provider (Form WH-380-E)**
□	**Paternity** *(Must be taken within one year of birth)*	**Certificate of Health Care Provider (Form WH-380-F)**
□	**Adoption/Placement of Foster Child** *(Must be taken within one year of placement)*	**Letter of Placement**
□	**Military Caregiver**	**Certification for Serious Illness or Injury of Covered Service Member (WH-385-V)**
□	**Military Exigency**	**Certification of Qualifying Exigency (DOL WH-384)**
	Personal Leaves (not FMLA eligible or not FMLA related)	
□	**Medical (non-FMLA)** *(Only available for staff member's own illness/injury)*	**Certification from Health Care Provider (Form WH-380-E)** *(Must include date condition began, probable duration, facts regarding staff member's medical condition and inability to work)*
□	**Military (non-FMLA)**	**Department of Defense Orders**
□	**Maternity (not eligible for FMLA)**	**Certification from Health Care Provider (Form WH-380-E)** *(including expected delivery date)*
□	**Other Personal**	**Explanation of Request**

Section 3: HR/BENEFITS SPECIALIST USE ONLY: Complete this section

Signature:	**Date:**

If this leave is for a Family Medical Leave:

(1) Has Staff Member had absences counted towards FMLA entitlement in the past 12 months? □ **YES** □ **NO**

If so, provide dates/hours which have already been applied towards FMLA, along with supporting documentation

Dates: From _____ to _____ Total hours of FMLA utilized during the past 12 months: _____

Total hours remaining of FMLA utilized during the past 12 months: _____

(2) If approved, will this leave be taken on an intermittent basis? □ **YES** □ **NO**
(Not available for adoption, placement in foster care or Paternity leave; only available for maternity leave if medically necessary)

(3) Is FMLA granted? □ **YES** □ **NO**
(4) If not FMLA eligible is Non-FMLA granted? □ **YES** □ **NO**