

Request for Part-Time Health Leave

If you have worked for the District for over a year, but do not work the designated hours for FMLA you may qualify for Part-Time Health Leave

Please refer to the Personnel Policies for Non-Exempt Classified Employees Handbook. When leave is due to a serious health condition, medical certification of the condition is required. Print or type your request and forward directly to the Benefits Office.

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Name: _____ Today's Date: _____

Employee ID: _____ School Name: _____

Date of Employment: _____ Job Title: _____

Home/Cell Phone: _____ Supervisor: _____

Personal E-mail address: _____

Current Mailing address: _____

I request the following type of leave for:

- A serious health condition that makes you unable to perform the essential functions of your job
- The birth of a child or the placement of a child with you for adoption or foster care
Anticipated Date of Birth _____

The start date of my leave is: _____

Requested time period/Return Date: _____

If your return date is to be determined – you must indicate a tentative return/time period

If at any point your paycheck will not cover the premiums for your insurance, payroll will send you a bill for payment. You **MUST** pay this bill in a timely manner as indicated on the statement you will receive, or your coverage may be cancelled due to your non-payment

I understand that by completing and signing this form I am initiating a leave request and will advise the Benefits Office directly regarding a need to cancel or reschedule.

You will receive written notification of the disposition of your request from the Benefits Office once all required information and documents are received and verified by Human Resources.

Signature: _____ Date: _____