PEQUANNOCK TOWNSHIP SCHOOL DISTRICT

LEAVE OF ABSENCE REQUEST

A written letter requesting family or medical leave must be attached to this document, along with a medical certification form from a health care provider certifying your need for a leave of absence. Failure to submit a medical certification may result in denial of the request. Unless this is an emergency leave, your request should be submitted at least **30 days prior** to the date the leave is to begin and **90 days prior for a maternity leave**.

Employee Name: _____ Date: _____

Title/Position: _____ School: _____

I request a family or medical leave for one or more of the following reasons:

☐ For my own serious health condition that makes me unable to perform my job. Submit medical documentation.

Leave start date: _____ Expected return date: _____

☐ Because of the birth of my child and in order to take care of the child. Medical documentation is required for your own disability due to the birth of the child.

Expected date of birth: _____
Leave start date: _____ Expected return date: _____

☐ Because of the placement of a child with me for adoption or foster care. Submit legal record of placement when available.

Expected date of birth: _____
Leave start date: _____ Expected return date: _____

☐ In order to care for my spouse, child, or parent, who has a serious health condition. Submit medical documentation.

Leave start date: _____ Expected return date: _____

☐ Proposed intermittent or reduced day leave schedule, if applicable. May be subject to supervisor/employer's approval. Submit medical documentation.

Leave start date: _____ Expected return date: _____

Have you taken a family or medical leave in the past 12 months: ☐ Yes ☐ No
If yes, how many days/weeks? _____ days _____ weeks

I understand and agree to the following:

1. I have been employed with the District for at least 12 months.
2. Number of sick days to be taken: _____
3. Accumulated sick days can only be used during the employee's own personal disability or illness.
4. All leaves of absence (paid and non-paid) are to be approved by the Board of Education.
5. A leave of absence for the employee's own "serious health condition" is only covered by FMLA.

Employee Signature: _____ Date: _____

It is my understanding that I am eligible for up to 12 weeks of leave per 12 month period under the Family and Medical Leave Act (hereinafter "FMLA") if I have worked at least 12 months, and at least 1,250 hours in the 12 months preceding the leave. I understand that the New Jersey Family Leave Act (hereinafter "NJFLA") differs from the FMLA and that under the NJFLA, I am eligible for 12 weeks of leave per 24 month period if I have worked at least 12 months, and at least 1,000 hours in the 12 months preceding the leave. If I am eligible for leave for reasons provided under the FMLA and NJFLA, then the time taken shall be concurrent and be applied to both laws. I understand that I shall notify the District as soon as practicable if dates of my scheduled leave change or are extended.

It is my understanding that upon return to the District following my leave(s), I will be reinstated to the position I held when leave commenced or to an equivalent position of like seniority, status, employment benefits, pay, and other conditions of employment.

It is also my understanding that the Board will continue my health insurance during my leave(s). I also understand that I will continue, during my leave, to pay health insurance premiums for which I may be responsible under the terms and conditions of my employment with the Board. Further, I understand that I have a minimum 30-day grace period following my receipt of an invoice from the District in which to make any such premium payments and that failure to do so may result in the cancellation of my health insurance coverage.

If leave is taken under FMLA, I understand that if I fail to return to work either after my period of leave expires, or for any reason other than the continuation, reoccurrence, or onset of a serious health condition that would entitle me to FMLA leave, or circumstances beyond my control, the Board is entitled to recover the premium that the Board paid for maintaining my health insurance coverage while on FMLA.

Further, if I fail to return to work after the expiration of the leave, I am expected to give adequate notice of same as required by the terms and conditions of my employment agreement.

I further understand that if I am eligible for New Jersey's Family Leave Insurance Program ("NJFLI"), the NJFLI benefits must be taken concurrently with leave taken pursuant to FMLA and/or NJFLA. NJFLI is not a leave entitlement, only a monetary benefit.

I acknowledge that completion of this form, in conjunction with Board policies and regulations regarding FMLA and/or NJFLA leave, adequately informs me of my rights and responsibilities with regard to leave under the FMLA as well as the NJFLA.

Employee Name: (Print) _____

Signature: _____ Date: _____