REQUEST FOR AN UNPAID LEAVE OF ABSENCE

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>PSL Number:</th>
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<td>Department/Site:</td>
<td>Classification:</td>
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PLEASE CHECK APPROPRIATE BOX(S): □ FMLA/CFRA □ UNPAID LEAVE

REASON FOR THE LEAVE (please check one):

___ Employee’s own illness or injury*
___ Employee’s own disability resulting from pregnancy/childbirth*
___ To care for spouse, parent or child with serious illness or injury*
___ To care for new born or newly adopted child or child newly placed in foster care
___ Personal
___ Other ____________________________________________________________________________

Beginning day/date: ____________________ Return day/date: ____________________

In requesting this leave of absence, I UNDERSTAND:

1. That, if my request is for pregnancy disability, medical or to care for a family member with a serious illness,
   • I must attach with this request, or submit within 10 days of this request, a Physician Certificate.
   • I must submit a certificate from my treating physician, before returning to work, stating that I am able to return to full
duties with or without reasonable accommodations.

2. That, if I do not return to work at the end of the leave, or make appropriate arrangements for an extension of my leave, I
shall be subject to disciplinary action up to and including termination from the District.

FAILURE TO SUBMIT THE CERTIFICATION MAY RESULT IN THE DENIAL OF THE LEAVE REQUEST.

Signature of Employee ____________________ Date ________________

RECOMMEND: APPROVAL ( ) DISAPPROVAL ( )

Signature (Immediate Supervisor) ____________________ Date ________________

APPROVED_____ DENIED______ BOARD APPROVAL DATE: ____________________
(Not required for FMLA/CFRA)

Signature of Superintendent ____________________ Date ________________

Signature of Human Resources Director-Classified ____________________ Date ________________