



SANTA PAULA UNIFIED SCHOOL DISTRICT
PERSONNEL COMMISSION
HUMAN RESOURCES DEPARTMENT CLASSIFIED

REQUEST FOR AN UNPAID LEAVE OF ABSENCE

Employee Name:	PSL Number:
Department/Site:	Classification:

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