



Dexter Community Schools Request for Leave of Absence

Please complete this form to request a Leave of Absence as soon as you know you need to be off of work for MORE THAN 5 consecutive work days.

SECTION 1 EMPLOYEE INFORMATION				
Name		Phone Number	Email	
Mailing address		City/ZIP	Group <input type="checkbox"/> Admin <input type="checkbox"/> Individuals <input type="checkbox"/> DEA <input type="checkbox"/> DESPA <input type="checkbox"/> WWBDBMA <input type="checkbox"/> Jenkins/Bates <input type="checkbox"/> Other	
School Year		Building	Position	
SECTION 2 LEAVE OF ABSENCE REQUEST				
Type of Leave Requested (see page 2 for definitions)				
<input type="checkbox"/> Family and Medical Leave Act (FMLA)		<input type="checkbox"/> Paid Leave <input type="checkbox"/> Partially Paid Leave <input type="checkbox"/> Unpaid Leave		
Reason for leave? <input type="checkbox"/> Maternity <input type="checkbox"/> Paternity <input type="checkbox"/> Adoption/Foster <input type="checkbox"/> Serious Health Condition <input type="checkbox"/> Military <input type="checkbox"/> Non-medical (describe _____)				
For who? <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other _____				
Does this person live in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Date Worked (estimate if exact date is not known)	First Date of Leave	Last Date of Leave	Date Return to Work
Number of Work days requested off	Use Banked Days (estimate # if not known)	Unpaid Days (estimate # if not known)		
SECTION 3 EMPLOYEE REQUEST				
I request the above Leave of Absence. I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Dexter Community Schools. <i>Please provide a copy of this form to your building principal/supervisor, a copy to Human Resources, and the original to the Business Office. Retain a copy for your records.</i>				
Print Name: _____				
Signature: _____		Date: _____		
Revised Date Return to Work* _____ (If you plan to return earlier than requested, you must notify your supervisor 5 work days in advance)				
FOR BUSINESS OFFICE USE ONLY				
Type of Leave Granted <input type="checkbox"/> Family and Medical Leave Act (FMLA) <input type="checkbox"/> Paid Medical Leave Act (PMLA) <input type="checkbox"/> Emergency Paid Sick Leave Act (EPSLA) <input type="checkbox"/> Emergency Family and Medical Leave Expansion Act (EFMLEA) <input type="checkbox"/> Other Paid Leave <input type="checkbox"/> Other Unpaid Leave				
<input type="checkbox"/> Notice/letter sent (date _____)		<input type="checkbox"/> Physician certification received (date _____)		
<input type="checkbox"/> Return to work release employee's medical) _____		<input type="checkbox"/> Employee terminated before returning to work (date _____)		
Days worked before leave <i>a)</i>	Last Date Worked	First Date of Leave	Last Date of Leave	Date Return to Work
Earned days adjusted for unpaid time	# leave days available	# leave days used/allowable <i>b)</i>	# unpaid days <i>c)</i>	Step Advancement? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contract Salary	Contract worked/paid _____/_____= % <i>a+b+c / contract days</i>	Adjusted Salary	Date to Term Insurance	FMLA weeks used

Definitions

Family and Medical Leave Act (FMLA) - Entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to:

- Twelve workweeks of leave in a 12-month period for:
 - the birth of a child and to care for the newborn child within one year of birth;
 - the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
 - to care for the employee's spouse, child, or parent who has a serious health condition;
 - a serious health condition that makes the employee unable to perform the essential functions of his or her job;
 - any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" **or**
- Twenty-six workweeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave).