

Request for CFRA/Parental Leave

Employee Section

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|-------------------------|--|
| Employee Name | |
| Employee Work Location | |
| Employee Position Title | |

I wish to request a leave of absence from my above listed position to begin on _____ and return on _____ (not to exceed 12 work weeks).

Certificated Staff – I understand that I must exhaust my sick leave and that I will be paid differential pay (not less than 50% of my pay).

Classified Staff – I understand that I must exhaust all available leaves (sick, vacation, etc) and that I will be paid differential pay (not less than 50% of my pay).

I understand that LESD will continue to pay for their portion of my health and welfare benefits (if applicable), but I am responsible for all dependent costs.

| | | | |
|--------------------|--|------|--|
| Employee Signature | | Date | |
|--------------------|--|------|--|

Human Resources Section

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|--|--|
| <input type="checkbox"/> Approved: _____ | <input type="checkbox"/> Not Approved: _____ |
| <i>Board Date</i> | <i>Reason not approved</i> |
| HR Signature & Date | |