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: ☐ Admin ☐ Individuals ☐ DEA ☐ DESPA ☐ WWBDBMA ☐ Jenkins/Bates ☐ Other	
School Year .	Building		Position	
SECTION 2 LEAVE OF ABSENCE REQUEST				
Type of Leave Requested (see page 2 for definitions) ☐ Family and Medical Leave Act (FMLA)	☐ Paid Leave ☐ Partially Paid Leave ☐ Unpaid Leave			
Reason for leave? ☐ Maternity ☐ Paternity ☐ Adoption/Foster ☐ Serious Health Condition ☐ Military ☐ Non-medical (describe____________)				
For who? ☐ Employee ☐ Spouse ☐ Child ☐ Parent ☐ Other ____________________				
Does this person live in your household? ☐ Yes ☐ 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. ***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.***

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
☐ Family and Medical Leave Act (FMLA) ☐ Paid Medical Leave Act (PMLA) ☐ Emergency Paid Sick Leave Act (EPSLA)
☐ Emergency Family and Medical Leave Expansion Act (EFMLEA) ☐ Other Paid Leave ☐ Other Unpaid Leave

☐ Notice/letter sent (date ____________) ☐ Physician certification received (date ____________)
☐ Return to work release employee's medical) _________ ☐ Employee terminated before returning to work (date _________________)

Days worked before leave *a)*	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 *b)*	# unpaid days c)	Step Advancement? ☐ Yes ☐ No
Contract Salary	Contract worked/paid ________/ _____ = % *a+b+c / contract days*	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).