Roseville Area Schools

# Leave of Absence Request Form

Employee Name:_____ Supervisor Name:_____

Position:_____ Work Location:_____

Type of Leave: ☐ Continuous ☐ Intermittent ☐ Reduced Schedule

Requested Leave Dates: Start:_____ End:_____ Return to Work:_____

**Medical Leave**:

- ☐ Employee Medical (employee's own serious health condition)
- ☐ Family Medical (for serious health condition of spouse, son/daughter under age 18 or disabled, parent, member of household)

Employees are required to use accumulated sick leave during a medical leave. If you would like to apply accumulated vacation or personal time, please indicate the number of days/hours: _____Sick _____Vacation/Personal

For any medical leave, Certification of Health Care Provider Form (WH-380) for the employee or family member verifying a serious medical condition needs to be completed and sent to Human Resources within 15 days of the leave request form.

- ☐ I have sent/faxed form WH-380 to Human Resources
- ☐ I have NOT sent form WH-380 and will send when completed by the physician.

**Parental Leave:**

- ☐ Pregnancy (Mothers only) – Attach a physician's statement indicating expected due date.
- ☐ Birth of a Child (Non-birthing parent) – Attach a physician's statement including expected due date.
- ☐ Placement of child through adoption or foster care – Attach adoption or placement verification court order.

In most cases, mothers are required to use sick leave for the portion of time off which is considered a medical disability – typically 6 weeks from the date of birth for a regular birth and 8 weeks for a cesarean section. If you would like to supplement your leave with paid time off, please indicate the number of days/hours below.

☐ Vacation ☐ Personal ☐ Sick

**Other Leave:**

- ☐ Mobility Leave (Per MN Statute 122A.46, 136F.43 and354.66)
- ☐ General, Non-Compensatory Leave. Attach an explanation of leave request.
- ☐ Military (As provided under FMLA and per MN Statute 192.61, Subdivision 1). Attach a copy of orders. Certification of Health Care Provider Form (WH-380) is required for service member FMLA.

I certify that the leave requested above is for the purpose(s) indicated. I understand that I must comply with my Labor Agreement and/or District Policy regarding eligibility and procedures for a leave of absence and this request is subject to District approval.

Employee Signature:_____ Date:_____

**Return to: Human Resources, Roseville Area Schools, 1251 Co Rd B2 W Roseville, MN 55113**