



PLEASANT VALLEY SCHOOL DISTRICT
HUMAN RESOURCES/PERSONNEL COMMISSION

Request for Medical/Other Leave of Absence

Employee Information			
Employee Name : (First and Last Name)			
Job Title:			
Department/School:			
Immediate Supervisor Name:			
Leave Dates:	Start	Expected Return	Is this a request to extend an existing leave? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Contact Information While on Leave:	Address		
	Phone	Email	
Request for Leave			
<p>IMPORTANT NOTE! <u>Employees must provide 30 days advance notice if leave is foreseeable.</u> Requests for leave due to an employee's serious illness/injury/childbirth, or for the care of a family member with a serious illness requires submission of a Certification of Health Care Provider to HR within 15 calendar days of submitting this form. You may also be required to provide documentation in connection with other types of leave. If you do not provide documentation in a timely manner, leave may be denied/discontinued.</p>			
<p>Type of Leave Requested:</p> <p><input type="checkbox"/> Medical leave for employee due to:</p> <p style="padding-left: 20px;"><input type="checkbox"/> My own serious health condition</p> <p style="padding-left: 20px;"><input type="checkbox"/> Pregnancy and/or childbirth – anticipated/actual delivery date: _____</p> <p><input type="checkbox"/> Parental Leave/bond <input type="checkbox"/> Newborn natural child – date of birth: _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> Newly placed adopted/foster child – date of placement in your home: _____</p> <p><input type="checkbox"/> Care for a family member with a serious health condition (must meet definition of family member under FMLA/CFRA)</p> <p style="padding-left: 20px;">Name of family member: _____ Relationship: _____</p> <p><input type="checkbox"/> Military leave (must attach copy of orders)</p> <p><input type="checkbox"/> Leave without pay</p> <p><input type="checkbox"/> Other:</p>			
Additional Information			
If leave is requested on an intermittent or reduced leave schedule, please indicate the days of the week and/or hours during the day you will be absent:			
Does your spouse work for PVSD? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, spouse's name:	
Employee Certification			
<ul style="list-style-type: none"> I understand that I must submit a Doctor's Release for Return to Work form prior to returning to work if the leave is for my own serious health condition. If the form is not received, I understand that my return to work will be delayed until the form is provided. I understand that new dependents must be added to my health insurance within 30 days of birth or placement, or I must wait for the next open enrollment period. Contact the Employee Benefits Specialist at (805) 445-8605 for benefit information. I understand that I may contact Human Resources at (805) 445-8663 if I have questions regarding leaves of absence. 			
Employee Signature:			Date:
Principal/Supervisor Signature:			Date:
HR Reviewed By:		Date:	