Lake Worth ISD Application for Extended Leave [more than 3 days]

Please type or print

Based on Policy DEC (Local)

Employee's name _____ Position _____ Campus/Dept._____

Date(s) of leave requested _____ Anticipated return date _____

Instructions for completing form. This form, based on local policy DEC, addresses leave that must be approved by the Superintendent or may require addition FMLA/TDL paperwork. Upon completion, give the form to your campus principal/supervisor who will sign it and forward the request to the Payroll Department for processing.

Type of Leave Requested – Please see Employee Handbook for leave policy.

☐ **Extended Leave** ***(includes maternity)*** ***Note: Employees who have been employed by*** **Lake Worth** ***ISD for the previous 12 months in a full-time capacity may qualify for FMLA leave.***

☐ I have been or will be absent more than three consecutive sick days (self). Dates _____

☐ I have been or will be absent more than three consecutive days for a family member who must have my presence.
☐ *spouse* ☐ *child* ☐ *parent* ☐ *other(specify)*_____ Dates _____

☐ The birth of my child, or the placement of a child for adoption or foster care
☐ A Serious health condition that makes me unable to perform the essential functions of my job. Other Specify: _____

☐ Additional Information [if applicable]:_____

☐ I understand that if I am granted the extended leave, that after state and local paid days are exhausted the remaining days will be docked as unpaid leave thru payroll.

☐ I further understand that I will be required to provide a Release to Work from my personal physician on or before returning to work in any capacity with Lake Worth ISD

Doctor's note is required if absent for more than three days

☐ **Assault Leave** *Campus principal/building supervisor must attach statement verifying physical assault, date, time, & injuries received.*
Date of physical assault _____Time of physical assault_____
Injuries received_____
I understand any assault leave benefits shall be coordinated with temporary income benefits due from workers' compensation so that my total compensation from temporary income benefits and assault leave will equal 100% of my weekly rate of pay.
I understand I will not be charged with State sick leave to accommodate physical assault leave.

☐ **Military Leave** *(attach a copy of orders)*

☐ **Bereavement Leave** *(death of an immediate family member. See DEC (Local))*

☐ **Discretionary Leave [must be approved by the Superintendent in advance]**
Additional Information [if applicable]: _____

_____ _____
Employee Signature *Date*

Administrator Acknowledgement ☐ **approved** ☐ **not approved** **Comments:**

_____ _____
Principal/Supervisor *Date forwarded to Benefits & Payroll Office*

Discretionary Leave ☐ approved ☐ not approved

_____ _____
Superintendent *Date*

HR and Payroll Manager ☐ approved ☐ not approved **FMLA** ☐ yes ☐ no FMLA hours_____

_____ _____
HR and Payroll Manager *Date Processed*

Revised 3/27/24