



Temple City Unified School District REQUEST FOR TIME OFF

Planned absences: form must be completed and approved in advance. **Unplanned absences:** complete form as soon as possible.

EMPLOYEE INFORMATION

Certificated Classified

Name: _____ Beginning date of leave: (month/day/year) _____

Position: _____ Ending date: (month/day/year) _____

EID: _____ Date to return to work: (month/day/year) _____

Work Site: _____

Employee Phone #: _____ Department: _____

Employee must verify available leave balance with Payroll : _____ Address while on leave: _____

_____ Sick Leave _____ Personal Business _____

_____ Vacation Leave _____ Floating Holiday _____

Date Verified: _____ Notes: _____

TYPE OF LEAVE REQUESTED:

- Medical (Non-Industrial) of more than 3 days – Attach documentation from health care provider
- Pregnancy Disability Leave - Attach documentation from health care provider
- Bereavement – Relationship of family member: _____
- Unpaid Leave of Absence - Attach letter explaining circumstances
- Vacation: _____
- Personal Business/Necessity: _____
- Other (Specify Reason): _____ Attach Explanation

FAMILY AND MEDICAL LEAVE (FMLA) and/or BABY BONDING LEAVE

Check appropriate box. If you are eligible, FMLA and/or Baby Bonding leave forms will be sent to you. **Attach explanation**

- Birth of a child or the placement of a child with you for adoption or foster care. Date of child's birth: _____
- A serious health condition that makes you unable to perform the essential functions for your job
- A serious health condition affecting your _____ spouse, _____ child, _____ parent, for which you are needed to provide care

Employee's Signature Date Supervisor's Signature Date

To be completed by Assistant Superintendent, Personnel	
<input type="checkbox"/> Leave Approved	*LEAVE WITHOUT PAY <input type="checkbox"/> Authorized Absence <input type="checkbox"/> Unauthorized Absence
<input type="checkbox"/> Leave Not Approved	Comments:
Date	Assistant Superintendent Signature

- This leave will require your benefits to be adjusted and/or your contract reissued.
- This leave **MAY** require benefits to be adjusted if additional unpaid days are taken.
- This leave **will require** a release or clearance to return to work from your doctor **BEFORE** you can work.
- Upon return from leave, you **MAY** be assigned to a different location or type of service.

Board Approval Date: _____ Personnel: _____ HRS input date: _____

Distribution: _____ Payroll _____ Site _____ Employee _____ Benefits