Visalia UNIFIED SCHOOL DISTRICT

REQUEST FOR LEAVE

Employee Name: _____ **Employee ID #:** _____ **HRS/Day:** _____

Work Site/Department: _____ **Position:** _____ **Phone #:** _____

☐ *CERTIFICATED (VUTA) ☐ CERTIFICATED MANAGEMENT ☐ CLASSIFIED (CSEA) ☐ CLASSIFIED MANAGEMENT

*FOR CERTIFICATED, CHECK BOX IF APPLICABLE:

☐ I am in the induction program. ☐ I am in a dual enrollment position with COS. ☐ I currently receive a prep buyout.

TYPE OF LEAVE REQUESTED

☐ **Discretionary Leave (4+ days):** Employees may use up to five days per year. HR Approval required to use more than three consecutive days. ***Certificated*** must have Sick Leave and PN available to use this leave. ***Classified*** must have Sick Leave available to use this leave.

Supervisor Review: *Please review this request to ensure it meets CBA requirements prior to submission for HR approval.*

☐ *This request **meets** the following CBA requirements:*

VUTA (IX, M): *No more than 8% of unit members at a site may use this leave on the same day.*

CSEA (15.8): *One unit member in each classification per department/site may use this leave on the same day or no more than 8% of unit members in Transportation.*

☐ *This request **does not meet** CBA requirements.*

_____ Signature _____ Print Name _____ Date

☐ **Military Leave:** For military leave, orders must be attached.

☐ **Sabbatical Leave:** Professional study or travel which will benefit the educational program of the District. **Detailed description of reason for the request must be attached.** See VUTA CBA for details and requirements.

☐ **Personal Illness:** Leave for employee's own illness or injury. Requires medical certification or doctor's note.

Check leave type: ☐ Continuous ☐ Intermittent

☐ **Family Illness :** To care for a qualifying family member due to a serious heath condition. Requires medical certification.

Check leave type: ☐ Continuous ☐ Intermittent

Check qualifying family member: ☐ Spouse ☐ Child ☐ Parent ☐ Domestic Partner ☐ Sibling ☐ Grandparent ☐ Grandchild

☐ Designated Person: _____

Name of Designated Person

_____

Relationship to Employee

MEDICAL CERTIFICATION

Certification of Health Care Provider Form must be completed by the treating Physician. This form is required for Family Illness Leave and can be used for Personal Illness Leave. A doctor's note that includes the dates of leave is acceptable for Personal Illness Leave only.

DATES OF REQUESTED LEAVE: _____ **TO** _____

REASON FOR REQUEST:

_____

_____

_____

I understand that my accumulated sick leave will be used to keep me in a fully paid status during my leave. If/when my sick leave is exhausted, I understand I will be subject to a payroll adjustment. Salary advancement for Management and Certificated employees may be impacted if the employee is not in a fully paid status for 75% of the year or more.

Signature: _____ Date: _____

FOR HRD USE ONLY

☐ **Approved** ☐ **Denied** Eligible for FMLA/CFRA ☐ Yes ☐ No

Comments: _____

_____

Approved/Denied By: _____ Date: _____

Return Form to: Human Resources/Employee Benefits
5000 W Cypress Ave, Visalia CA 93277