REQUEST FOR UNPAID LEAVE

Visalia Unified School District

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

***Certificated**

☐ **Health Leave of Absence:** Unpaid leave of absence due to employee's own illness/accident for up to one semester. This leave requires medical certification.

☐ **Personal Leave of Absence:** Unpaid leave approved by Superintendent. More than 15 days may require Board approval. Include reasons and supporting documentation with request.

☐ **Business Leave (4+ days) :** Unpaid leave to address business interests related to a business owned or co-owned by the unit member.

***Classified**

☐ **General Leave of Absence:** Generally unpaid leave requested when no other leave is available.

Unpaid leave may have an impact on your service credit with CalPERS or CalSTRS. Contact CalPERS (888) 225-7377 or CalSTRS (800) 228-5453 for additional information.

***Per the Employee Compensation Policy, 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.**

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

REASON FOR REQUEST:

_____

_____

_____

HEALTH INSURANCE OPTIONS FOR UNPAID LEAVE IN EXCESS OF 15 WORKING DAYS

☐ N/A

☐ I **DO NOT** wish to continue my health insurance coverage during the period of unpaid leave. I understand that it is my responsibility to reapply for health insurance coverage upon my return to paid status.

☐ I **DO** wish to continue my health insurance coverage during the period of unpaid leave and I understand it is my responsibility to make monthly premium payments by the 1st of each month to the VUSD Benefits Office. Failure to submit timely premium payments shall be cause for cancellation of health, dental and vision coverage.

Monthly Amount to continue coverage $ _____ commencing on _____

Signature: _____ Date: _____

FOR HRD USE ONLY

☐ **Approved** ☐ **Denied**

Comments:

_____

_____

Approved/Denied By: _____ Date: _____

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