

## LEAVE OF ABSENCE REQUEST

Please complete this entire form and return it to your Office Manager. Leave status will be calculated and a copy sent to you. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE MANAGER AND HUMAN RESOURCE ASSOCIATE AT THE INCEPTION AND OFFICIAL RETURN OF MY LEAVE.

NAME: \_\_\_\_\_ EMPLOYEE ID: \_\_\_\_\_ Phone Number \_\_\_\_\_

WORK LOCATION: \_\_\_\_\_ ESTIMATED DATE LEAVE TO BEGIN: \_\_\_\_\_

POSITION: \_\_\_\_\_ ESTIMATED DATE RETURN TO WORK: \_\_\_\_\_

DATE OF REQUEST: \_\_\_\_\_ NAME OF PRE-ARRANGED SUBSTITUTE (if applicable): \_\_\_\_\_

**Request required for reasons below for absences 6 days or more.**

☐ **\*MEDICAL LEAVE** (\*\*Doctor's note must be attached)

☐ **FAMILY ILLNESS** (\*\*Doctor's note must be attached)

☐ **\*PARENTAL** (\*\*Doctor's note must be attached)  
(Earned Paid Time Off leave may be used for first 6 weeks from date of birth for medical purposes)  
Due Date \_\_\_\_\_

☐ **ADOPTION LEAVE**  
(Earned Paid Time Off leave may be used for first 6 weeks from adoption)

**MILITARY LEAVE**

☐ **WORKER'S COMPENSATION** (\*\*Doctor's note must be attached)

**\*\*Failure to attach note may result in unpaid leave.**

☐ I understand I must use any earned leave to cover the time of the leave when I am physically unable to work (up to 6 weeks from childbirth for maternity leave/ adoption or 8 weeks for a C-section).

☐ I understand for a Medical/Maternity Leave, Family Illness, Employee, Child, Spouse quarantine or Workman's Compensation - I must use leave available. Leave will be deducted as follows: Paid Time Off, Comp Time and Vacation.

☐ I understand for a Medical/Maternity Leave, Family Illness or Workman's Compensation- Failure to return Certification of Healthcare Provider within the allotted time may result in any absences not being designated as FMLA protected leave.

I meet all guidelines listed below (which may allow my participation in **Family Medical Leave (FMLA)**):

- 1) Worked for CUSD for at least 12 months.
- 2) Worked at least 1250 hours during 12 months prior to the start of FMLA leave.
- 3) Have not taken 12 weeks of FMLA in the last 12 months.
- 4) I intend to return to work at the end of my approved leave of absence.

YES ☐

NO ☐

*\*Employees on medical or maternity leave are expected to return to work upon full release from their physician. Prior to returning to work, you **must** submit a physician's release to your site Office Manager who will then forward a copy to the attention of your Human Resource Associate **a minimum of 2 days prior to your return. If released with restrictions, please contact HR for approval prior to reporting to work.***

\_\_\_\_\_  
Employee Signature – Signature indicates agreement to terms listed above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date