

ABSENCE CLAIM FORM

DIRECTIONS: THIS FORM MUST BE COMPLETED AND GIVEN TO YOUR SITE ADMINISTRATOR FOR AUTHORIZATION. COMPLETED AND SIGNED FORMS WITH REQUIRED PAPERWORK ATTACHED, MUST BE TURNED INTO HUMAN RESOURCES FOR PROCESSING. ALL LEAVES MUST BE REQUESTED IN A PROACTIVE AND TIMELY MANNER THAT LEAST IMPACTS BUSINESS OPERATIONS, EXCEPT IN URGENT EMERGENCY CASES, WHERE PROACTIVE NOTIFICATION IS IMPOSSIBLE. FOR ANY LEAVE REQUEST PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF THE SPACE IS INSUFFICIENT. DEPENDING ON THE REQUEST YOU MAY BE REQUIRED TO FILL OUT ADDITIONAL FORMS. NOT ALL LEAVE SECTIONS MAY BE APPLICABLE TO ALL DISTRICT EMPLOYEES OR BARGAINING UNITS, & SOME DETAILS WITHIN A PARTICULAR SECTION MAY NOT BE APPLICABLE TO A PARTICULAR BARGAINING UNIT.

EMPLOYEE NAME: _____	DATE: ____/____/____
DATES OF ABSENCE, START DATE: ____/____/____ START TIME: ____ am./pm.	TOTAL NUMBER OF DAYS: _____ HOURS: _____ ABSENT
DATES OF ABSENCE, END DATE: ____/____/____ END TIME: ____ am./pm.	

CHECK ☒ THE REASON OF ABSENCE BELOW:

☐ **1. PERSONAL ILLNESS ("Sick Time"):** TO RECEIVE COMPENSATION FOR SICK LEAVE, THE EMPLOYEE MUST NOTIFY HIS/HER SUPERVISOR OF HIS/HER ABSENCE AS INDICATED WITHIN THE APPLICABLE CONTRACT OR PERSONNEL COMMISSION RULES, UNLESS CONDITIONS MAKE NOTIFICATION IMPOSSIBLE. THE BURDEN OF PROOF OF IMPOSSIBLE CONDITIONS IS UPON THE EMPLOYEE.

☐ **2. MEDICAL LEAVE OF ABSENCE:** MEDICAL LEAVE OF ABSENCES WILL IMMEDIATELY BE CHARGED TO THE EMPLOYEE'S AVAILABLE FULL-PAY SICK TIME. AN EMPLOYEE MUST ATTACH AN ORIGINAL STATEMENT FROM A STATE LICENSED MEDICAL PROFESSIONAL INDICATING THE SPECIFIC DATES FOR THE LENGTH OF TIME TO BE OFF WORK, FOR SUBMISSION TO THEIR SUPERVISOR FOR VERIFICATION AND APPROVAL. THEN THIS FORM AND THE ATTACHED DOCTOR'S NOTE MUST BE FORWARDED TO HUMAN RESOURCES. IN ORDER TO RETURN TO WORK FOLLOWING A MEDICAL LEAVE OF ABSENCE THE EMPLOYEE MUST SUBMIT A RETURN TO WORK CLEARANCE FROM THE DOCTOR OR MEDICAL CARE PROVIDER TO HUMAN RESOURCES OR THE OFFICE OF RISK MANAGEMENT FOR I. A. CLAIMS. FOR REPRESENTED CERTIFICATED EMPLOYEES: SECTION 15.2.5 WILL BE APPLIED.

UNPAID MEDICAL LEAVE: AFTER ALL PAID LEAVES HAVE BEEN EXHAUSTED; AN EMPLOYEE MAY REQUEST TO USE UNPAID MEDICAL LEAVE UPON WRITTEN REQUEST IN BOX #5 ON THIS FORM.

PROCEDURES FOR CLASSIFIED EMPLOYEES:

- IF AN EMPLOYEE MUST REMAIN OFF OF WORK AFTER USING ALL OF THEIR FULL-PAY SICK TIME, THEN HALF-PAY SICK TIME WILL BE AVAILABLE TO THE EMPLOYEE, NOT TO EXCEED 100 DAYS. PRIOR TO USING HALF-PAY SICK TIME OR AFTER ALL HALF-PAY SICK TIME HAS BEEN USED, AN EMPLOYEE MAY ELECT TO USE ANY OTHER PAID LEAVE TIME AVAILABLE TO THEM. AN EMPLOYEE MUST SELECT HOW THEY WISH TO USE THEIR TIME DIRECTLY BELOW. ALL MEDICAL LEAVE MAY BE SUBJECT TO ADJUSTMENT FOR APPROPRIATE APPLICATION. PAYROLL DEPARTMENT WILL DEFAULT TO OPTION 1 UNLESS OPTION 2 IS SELECTED BY THE EMPLOYEE.

- ☐ **OPTION 1:** USE: (1) ALL FULL-PAY MEDICAL LEAVE "SICK TIME" (2) HALF-PAY MEDICAL LEAVE (3) ANY OTHER APPROPRIATE LEAVE AVAILABLE
- ☐ **OPTION 2:** USE: (1) ALL FULL-PAY MEDICAL LEAVE "SICK TIME" (2) ANY OTHER APPROPRIATE LEAVE AVAILABLE (3) HALF-PAY MEDICAL LEAVE

☐ **3. MATERNITY LEAVE OF ABSENCE:** MATERNITY LEAVE FORMS ARE AVAILABLE IN HUMAN RESOURCES.

☐ **4. PERSONAL NECESSITY LEAVE:** SOME PERMANENT EMPLOYEES MAY HAVE THE RIGHT TO CLAIM UP TO SEVEN (7) DAYS PER YEAR

CHECK ONE: ☐ **EMERGENCY LEAVE** ☐ **NON-EMERGENCY LEAVE** SPECIFY NATURE: _____

☐ **5. PERSONAL BUSINESS:** A LEAVE OF ABSENCE WITHOUT PAY MAY BE GRANTED TO A PERMANENT CLASSIFIED EMPLOYEE UPON WRITTEN REQUEST, & THE APPROVAL OF THE SITE ADMINISTRATOR, & THE SUPERINTENDENT, OR HIS/HER DESIGNATED REPRESENTATIVE.

NOTE: A WRITTEN EXPLANATION MUST BE ATTACHED TO THIS FORM WITH A SIGNED AUTHORIZATION FROM THE SITE ADMINISTRATOR TO BE FORWARDED TO THE SUPERINTENDENT FOR CONSIDERATION.

☐ **6. FAMILY MEDICAL LEAVE ACT (FMLA):** EMPLOYEES WHO HAVE WORKED 1250 HOURS IN THE YEAR PRECEDING THE LEAVE REQUEST MAY BE ELIGIBLE FOR FMLA. FMLA FORMS CAN BE ACQUIRED IN THE HUMAN RESOURCES.

☐ **7. VACATION:** VACATION TIME MUST BE PRE-APPROVED AND AGREED TO BY THE SUPERVISOR/ADMINISTRATOR. CLASSIFIED EMPLOYEES:

- UNEARNED VACATION FOR REGULAR PERMANENT EMPLOYEES: WITH SUPERVISORY APPROVAL, PERMANENT EMPLOYEES MAY TAKE VACATION WITHIN A MONTH PRIOR TO COMPLETING A MONTH OF WORK. IF THE EMPLOYEE SEPARATES FROM THE DISTRICT PRIOR TO EARNING ANY USED VACATION, THAT EMPLOYEE WILL BE REQUIRED TO COMPENSATE THE DISTRICT FOR THE UNEARNED VACATION.
- PROBATIONARY PERIOD: PROBATIONARY EMPLOYEES MAY NOT TAKE ANY VACATION TIME DURING PROBATION. VACATION TIME WILL BE CALCULATED FOR THE PROBATIONARY PERIOD TO BE VESTED AND USED ONCE A PROBATIONARY EMPLOYEE IS PERMANENT. IF AN EMPLOYEE SEPARATES FROM THE DISTRICT DURING THEIR PROBATIONARY PERIOD, THAT EMPLOYEE WILL NOT BE ENTITLED TO ANY VACATION PAY.

☐ **8. FLOATING HOLIDAY(S):** MUST BE PRE-APPROVED BY SUPERVISOR. DAYS CANNOT BE TRANSFERRED TO A SUBSEQUENT FISCAL YEAR.

☐ **9. BEREAVEMENT LEAVE:**

CHECK ONE: ☐ **LOCAL** ☐ **EXTENDED TRAVEL** INDICATE LOCATION: CITY _____ STATE _____

☐ **10. JURY DUTY:** JURY SUMMONS MUST BE ATTACHED & SUBMITTED WITH THIS DOCUMENT.

☐ **11. MILITARY LEAVE:** LEAVE PAPERS/ORDERS MUST BE SUBMITTED WITH THIS DOCUMENT.

☐ **12. INDUSTRIAL ACCIDENT:** SUPERVISOR'S REPORT OF EMPLOYEE INJURY MUST BE FORWARDED TO THE RISK MANAGEMENT OFFICE.

☐ **13. OTHER:** EXPLAIN REASON: _____

THIS IS TO CERTIFY THAT (I WAS), OR (I WILL BE) ABSENT FROM WORK ON THE DATE(S) ABOVE.

EMPLOYEE'S SIGNATURE: _____ DATE: ____/____/____

ADMINISTRATOR'S SIGNATURE: _____ DATE: ____/____/____

FOR USE BY THE SUPERINTENDENT OR HIS/HER DESIGNEE

PERSONAL BUSINESS LEAVE (ITEM #5 ABOVE): ☐ **APPROVED** ☐ **DENIED**

SUPERINTENDENT'S SIGNATURE: _____ DATE: ____/____/____