

Leave Request Form-FMLA/Worker's comp/Long Term Unpaid

Complete this form at least thirty (30) days prior to the start of your leave.
A leave is defined as an absence, paid or unpaid, of more than five (5) consecutive days.

Part I: Employee Information				
Name:			Employee #:	
Preferred Phone #:		District Email: (personal e-mail may not be used for privacy concerns)		
School/Location:		Position:		
Supervisor:		Do you currently carry our medical insurance? ☐ YES ☐ NO		
Part II: Leave of Absence Information				
Anticipated Leave Start Date:			Anticipated Leave Return Date:	
I am requesting: ☐ up to 12 weeks off per Category 1 or ☐ the remainder of the year off per Category 2				
Select a Leave of Absence Reason: (place a check next to requested type of leave)				
CATEGORY 1 - FMLA Defined (up to 12 weeks)			Applicable Board Policy	
☐	Sick Leave – serious health condition for self, birth/adoption		03.1232/03.2232	
☐	Sick Leave – serious health condition for family member		03.1232/03.2232	
☐	Sick Leave – to care for a covered service member		03.1232/03.2232	
☐	Qualifying Exigency – military family leave		03.12322/03.22322	
CATEGORY 2 - Non-FMLA Defined (remainder of school year)			Applicable Board Policy	
☐	Maternity/Paternity Leave – birth/adoption		03.1233/03.2233	
☐	Extended Disability Leave		03.1234/03.2234	
☐	Military/Disaster Services Leave		03.1238/03.2238	
Other			Applicable Board Policy	
☐	Workers' Compensation		03.1241/03.2241	
☐	Other		List Policy:	
Please fill in the type and number of days you will be using during your leave of absence.				
Sick	Donated Sick	Personal	Unpaid	Other- Explain
If you are in need of donated sick leave, have you completed the form to request donations? ☐ YES ☐ NO ☐ DO NOT NEED				
Note:				
- Employees are required to use all paid leave days, if available, for all FMLA Defined Leave, except that the employee may request to reserve up to ten (10) days of sick leave, up to ten (10) days of vacation leave, and all available days of personal leave - Paid sick leave shall be used in accordance with Board Policy 03.1233/03.2233 - Maternity/Paternity Leave; immediately following the birth or adoption of a child or children				

Leave Request Form

Part III: Long-Term Substitute Request (For Certified Employees Only)		
Requested Substitute's Name: (must be an active substitute in the District)		
Note: • A certified substitute must be used for absences of more than nineteen (19) consecutive days • A certified substitute is someone that has a teaching certificate or SOE • Emergency substitutes do not have a teaching certificate, cannot be paid long term wages (absences for more than nineteen (19) consecutive days) and are not eligible to fulfill a long-term absence		
Part IV: Employee Responsibilities (please read and initial each)		
	I will abide by all applicable board policies, state and federal regulations governing a leave of absence.	
	I understand that my benefits, including health insurance, will be terminated once I am in an unpaid status or at the end of twelve (12) weeks if eligible for FMLA. I may be eligible for COBRA and should contact the District's Benefits Team at 606-663-3300 for more information.	
	I understand that I must notify Human Resources if the start date or end date of my leave changes.	
	I must notify Human Resources prior to returning from a leave of absence to determine if/when I may return to work, and, if applicable, provide a return to work note from my doctor.	
	It is my responsibility to keep all contact information (email, mail and phone) current while on a leave of absence.	
	I am aware unpaid days may negatively affect my annual retirement service credit* and annual pay increases**. *Contact your retirement system for more information. ** If I do not work 140 days of my certified annual contract or half of my classified annual contract, I will not receive an annual step increase.	
	In the event I am incapacitated or not of sound mind to communicate my leave of absence intentions with a member of the District, I approve the following individual permission to speak to, and provide information on my behalf with, Human Resources: Name of Individual: _____ Contact Phone #: _____ Relationship: _____	
Part V: Signature		
Employee Signature:		Date:
Printed Name:		
Part VI: District Approval/Denial (Office Use Only)		
Approved or Denied (List Denial Reason(s)):		
Superintendent/designee Signature:		Date:
Part VII: HR/Benefits (Office Use Only)		
FMLA Start Date	FMLA End Date	Board Agenda Date
Amendment #1	Amendment #2	Amendment #3
Amendment #4	Amendment #5	Amendment #6

Long Term Leave of Absence

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave per school year to “eligible” employees for certain family and medical reasons (days do not have to be consecutive). Employees are eligible if they have worked for a covered employer for at least one (1) year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

REASONS FOR TAKING LEAVE

Unpaid leave must be granted for any of the following reasons:

1. For the birth and care of an employee’s newborn child , or for placement of a child with the employee for adoption or foster care;
2. To care for the employee's spouse, child or parent who has a serious health condition, as defined by federal law;
3. For an employee's own serious health condition, as defined by federal law, that makes the employee unable to perform the employee's job;
4. To address a qualifying exigency (need) defined by federal regulation in connection with a family member’s (spouse, son, daughter, or parent) active duty or call to active duty in the Armed Forces/Reserves; and
5. To care for a covered service member or veteran (spouse, son, daughter, parent or next of kin) who has incurred or aggravated a serious injury or illness that I believe qualifies me to take FMLA military caregiver leave.

At the employee’s or employer’s option, certain kinds of paid leave may be substituted for unpaid leave.

ADVANCE NOTICE AND MEDICAL CERTIFICATION

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

The employee ordinarily must provide 30 days advance notice when the leave is “foreseeable.”

An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer’s expense) and a fitness for duty report to return to work.

JOB BENEFITS AND PROTECTION

For the duration of FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan”, as long as the employee pays premiums that are his/her responsibility.

Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Long Term Leave of Absence

UNLAWFUL ACTS BY EMPLOYERS

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA

ENFORCEMENT

The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.

An eligible employee may bring a civil action against any employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

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