



Leave of Absence Request Form

Employee Name: _____ Supervisor Name: _____

Position: _____ Work Location: _____

Type of Leave: ___Continuous ___Intermittent ___Reduced Schedule

Requested Leave Dates: Start: _____ End: _____ Return to Work: _____

Medical Leave:

- Employee Medical (employee's own serious health condition)
- Family Medical (for serious health condition of spouse, child under age 18/ child age 18 or older and incapable of self-care because of a mental or physical disability, parent, member of household)

Employees are required to use accumulated sick leave during a medical leave. If you would like to apply accumulated vacation or personal time, please indicate the number of days/hours: _____ Sick _____ Vacation/Personal

For any medical leave, Certification of Health Care Provider Form (WH-380) for the employee or family member verifying a serious medical condition needs to be completed and sent to Human Resources within 15 days of the leave request form.

- I have sent/faxed form WH-380 to Human Resources
- I have NOT sent form WH-380 and will send when completed by the physician.

Parental Leave:

- Pregnancy (Mothers only) – Attach a physician's statement indicating expected due date.
- Birth of a Child (Non-birthing parent) – Attach a physician's statement including expected due date.
- Placement of child through adoption or foster care – Attach adoption or placement verification court order.

In most cases, mothers are required to use sick leave for the portion of time off which is considered a medical disability – typically 6 weeks from the date of birth for a regular birth and 8 weeks for a cesarean section. If you would like to supplement your leave with paid time off, please indicate the number of days/hours below.

_____ Vacation _____ Personal _____ Sick

Other Leave:

- Minnesota Paid Family Medical Leave (**effective 2026**) (Per MN Statute 268B)
- Mobility Leave (Per MN Statute 122A.46, 136F.43 and 354.66)
- General, Non-Compensatory Leave. Attach an explanation of leave request.
- Military (As provided under FMLA and per MN Statute 192.61, Subdivision 1). Attach a copy of orders. Certification of Health Care Provider Form (WH-380) is required for service member FMLA.

I certify that the leave requested above is for the purpose(s) indicated. I understand that I must comply with my Labor Agreement and/or District Policy regarding eligibility and procedures for a leave of absence and this request is subject to District approval.

Employee Signature: _____ Date: _____