

LEAVE OF ABSENCE REQUEST

If complete and sufficient information is not provided in a timely manner, your leave may be denied.

Please consult with specific collective bargaining agreements and District policies for further information regarding the use of paid and unpaid leave.

Employee Information:	
Employee Name: _____	
Supervisor Name: _____	Location: _____
Position: _____	Employee Group: _____
Request Type: _____	School Year: _____
Preferred Contact Email while on leave: _____	Preferred Phone: _____
Employee Signature: _____	Date: _____
Leave Dates (Check all that apply):	
<input type="checkbox"/> Full time leave I am requesting continuous leave from _____ to _____ Expected return to work date: _____	
<input type="checkbox"/> Intermittent Leave I am requesting intermittent leave from _____ to _____	
<input type="checkbox"/> Part time/Reduced schedule leave Hours/Days I will NOT work: _____	
Type of Leave Request (Check all that apply)	
FMLA/Medical Leave: A Certification of Health Care Form must be submitted to, and completed by, your healthcare provider for any leave request that is medical in nature. Your return to work is also contingent upon medical clearance from your healthcare provider and your ability to perform the essential job functions of your position, with or without accommodations. You may be qualified to take FMLA leave if you have been a contracted employee of South Kitsap School District for at least 12 months and you have worked at least 1,250 hours during the 12-month period/school year immediately preceding the leave. https://www.dol.gov/agencies/whd/fmla	
I am requesting FMLA/Medical Leave (Select from the reasons below):	
<input type="checkbox"/> Medical Leave: Requesting for myself for a condition that renders me unable to perform my job. (Must complete the FMLA Medical Certification)	
<input type="checkbox"/> Family Leave: To care for my spouse, child or parent with a serious/terminal health condition. (Must complete the FMLA Medical Certification)	
<input type="checkbox"/> Military Exigency: A qualifying exigency arising from the employee's spouse, son, daughter, or parent being a covered military member on "covered active duty". (Must provide military orders)	
<input type="checkbox"/> Military Caregiver Leave: To care for a covered servicemember with a serious injury or illness incurred by the servicemember in the line of duty in active duty. (Must complete the FMLA Medical Certification and provide military orders)	
Paid Family & Medical Leave (PFML): This is a state paid benefit that does provide job/position or benefit protection and all decisions regarding eligibility, compensation, and timelines, are solely administered by Washington State's Employment Security Department. FMLA will run concurrently with PFML. For more information go to: https://paidleave.wa.gov	
<input type="checkbox"/> I have or plan to apply for Washington State Paid Family Medical Leave (PFML): <input type="checkbox"/> Yes <input type="checkbox"/> No It is my intention to use Paid Family Medical Leave from _____ to _____	
Your FMLA has been <input type="checkbox"/> Approved <input type="checkbox"/> Denied:	
You do not meet the eligibility requirements due to:	
<input type="checkbox"/> not having 1250 hours worked in the previous 12 months. <input type="checkbox"/> HR did not receive the medical certificate. <input type="checkbox"/> you have used all eligible FMLA entitlement.	
HR Analyst: _____	Date: _____