



LEAVE OF ABSENCE REQUEST

Clear Form

EMPLOYEE INFORMATION

Employee Name: _____ Employee ID Number: _____
Address: _____
Email Address: _____ Phone Number: _____
Site: _____ Division: _____ Position: _____

LEAVE OF ABSENCE

The dates of requested leave are from: _____ Through: _____

For the reason below: *(for any leave considered medical leave, please attach a doctor's note when submitting your request)*

☐ Sick Leave/Extended (<i>Over 5 days, less than 5 days form not needed</i>) Select one ☐ Self ☐ Family Member	☐ FMLA/CFRA Select one ☐ Self ☐ Family Member	☐ Personal Leave Short Term (*Unpaid)	☐ Leave Without Pay Long Term (*Unpaid)
☐ Pregnancy Disability Leave (<i>Maternity</i>) Due Date: _____	☐ Parental (Baby Bonding) (<i>FMLA/CFRA</i>)		☐ Parental (Baby Bonding) (<i>Non-Disability- *Unpaid</i>)
☐ Child Rearing (*Unpaid)	☐ Extended, Bereavement (<i>Select leave: Sick Leave, Vacation, Comp Time</i>)		☐ Industrial/Worker's Comp
☐ Military	☐ Health Rehabilitation (<i>Certificated Only-Unpaid</i>)		☐ Sabbatical (<i>Certificated Only</i>)
☐ Catastrophic Leave	☐ Elected Office	☐ Legislative	☐ Federation/Assoc

***(Unpaid) While on an UNPAID Leave, Medical Benefits will end on the last day of the month in which you begin an UNPAID Leave of Absence**

Employee Signature: _____ Date: _____

School/Dept. Administrator/Supervisor Signature: _____ Date: _____

HUMAN RESOURCES USE ONLY

☐ Approved

☐ Denied

Comments _____

Human Resources Signature: _____ Date: _____
Please refer to the appropriate contract provisions of your Agreement for detailed information, including priorities and restrictions. Bargaining Unit Agreements for Certificated Article 11, Classified Article 13, Paraeducator Article 11, Campus Supervisor Article 11.