



FORT WORTH INDEPENDENT SCHOOL DISTRICT
Leave of Absence

PERSONAL DATA

Name: _____ Employee ID#: _____
Last First MI

Location #: _____ School: _____ Supervisor: _____

Job Title: _____ Last Working Day: _____ LOA Effective Date: _____

Address: _____
Street Address City/State Zip

10-digit phone #: _____ Personal e-mail: _____

LEAVE OF ABSENCE STATEMENT
(to be completed by employee)

Employee reason for Leave of Absence (LOA):

- ☐ Family Medical Leave (FMLA) – Please check all that apply for FMLA
 ☐ For Self
 ☐ Caring for Immediate family member
 ☐ Intermittent
- ☐ Local Pregnancy/Parenting/Adoption (LPPA)
- ☐ Temporary Disability Leave (TDL)
 ☐ Workers' Compensation
- ☐ Military
- ☐ Regular
- ☐ Assault

MEDICALLY RELATED LEAVES OF ABSENCE WILL BE CONSIDERED TEMPORARY DISABILITY LEAVES ALL PURSUANT TO BOARD OF EDUCATION POLICY DEC (LOCAL).

Received Date Stamp:

By my signature, I state that I am voluntarily requesting a leave of absence.

An **Initial Letter** will be sent to your home address explaining how to continue your benefits "while on leave of absence". Please contact the Benefits Office at benefits@fwisd.org or 817-814-2240, if you have additional questions.

Employee Signature

Date

LEAVES AND ADA MANAGEMENT USE ONLY

Leave Begins: _____

DOH: _____

Previous LOA: _____

SmartFind Check: _____

☐ 95 = Family Medical Leave (FML) ☐ Self ☐ Family ☐ Intermittent

FML Expires: _____

☐ 94/95 = LPPA/FMLA

LPPA Expires: _____

FML Expires: _____

☐ 95/93 = FMLA/TDL

FML Expires: _____

TDL Expires: _____

☐ 95/97 = FMLA/Wk Comp

FML Expires: _____

WC Expires: _____

☐ 94 = LPPA only

LPPA Expires: _____

☐ 93 = TDL only

TDL Expires: _____

☐ 92 = Military

Military Expires: _____

☐ 97 = Worker's Comp (TDL)

WC Expires: _____

☐ 93A = Assault Leave

Assault Leave Expires: _____

☐ 95R = Regular Leave

Regular Leave Expires: _____

Comments:

Updated certification needed after: _____

Processed by: Leaves and ADA Coordinator

Date

Workers' Compensation Claims ONLY

Accrued Leave Election Form

Under the Texas Workers' Compensation Act (the Act), if your injury or illness results in lost-time from work, you may be entitled to income benefits. In addition, the Act provides (Texas Labor Code Section 504.052 - Sick Leave Benefits):

- a. The governing body of a political sub-division, by majority vote, may provide that while an employee of the political sub-division is receiving benefits under this chapter, the employee may elect to receive previously accrued sick leave benefits, whether statutory or contractual, in an amount equal to the difference between the benefits under this chapter and the weekly compensation that the employee was receiving before the injury that resulted in the claim.
- b. Sick leave benefits received under subsection (a) shall be deducted proportionally from the employee's sick leave balance.
- c. This section does not limit the medical benefits to be paid to the employee. A sick leave plan may not require an employee to take sick leave benefits before receiving benefits under this chapter.

Please indicate your election regarding the use of your accrued leave balances below, print your name, sign your name, and annotate the date appropriately.

I do ☐ / I do not ☐ elect to use my available (sick, vacation, personal) leave balances in order to receive benefits in an amount equal to the difference between the benefits I may receive under the Texas Workers' Compensation Act and the weekly compensation I was receiving before my injury or illness that resulted in my work-related injury claim.

Employee's Printed Name (First/Middle Initial/Last Name)

Employee ID. Number

Employee's Signature

Date

Date of Injury:

Location#