



Emmett School District #221
REQUEST FOR LEAVE OF ABSENCE

Employee Name: _____
Position: _____ **Location:** _____
Requested Leave Start Date: _____ **Return to work on:** _____
Total # of Days requested for leave: _____ **Circle:** MEDICAL or PERSONAL

District Policy 5400- Personal and Emergency Leave: *Upon recommendation of the Superintendent, and in accordance with law and District policy, classified staff may be granted personal leave pursuant to the following conditions: 1) Leave will be without pay unless otherwise stated. If leaves are to include expenses payable by the District, the leave approval will so state; 2) Leave will only be granted in units of half or full days; 3) Notice of at least one week is required for any personal leave of less than one week. Notice of one month is required for any personal leave exceeding one week; 4) The Superintendent, with approval of the Board, shall have the flexibility, in unusual or exceptional circumstances, to grant personal leave to employees not covered by sick or any other District recognized leave. During any personal leave of greater than 15 days, the employee will not receive fringe benefits. During the leave, the employee may pay the District's share of any insurance benefit program in order to maintain those benefits, provided that such is acceptable to the insurance carrier. Staff using personal leave shall not earn any sick leave or annual leave credit or any other benefits during the approved leave of absence.*

Conditions of Personal Unpaid Leave: Please read each statement carefully. Initial each item to acknowledge that you have reviewed and understand the conditions of your requested leave.

_____ **Explanation Letter:** I am including a letter of explanation to this application to explain the purpose of my leave and why I am requesting the superintendent to approve my request and hold my position through my Return Date.

_____ **Wage Accrual:** I understand that any leave of absence is unpaid. I will not earn wages, paid leave, PERSI contribution, accrue paid time off, or other compensation during the approved leave period.

_____ **Insurance Benefits:** I understand that if I choose to continue my insurance coverage during my leave, I am responsible for paying the full monthly premium to the District. The District will not contribute toward insurance premiums during this leave. Failure to make the required premium payments may result in cancellation of my insurance coverage, subject to the terms of the applicable benefit plans.

_____ **Premium Payment Schedule:** I understand that insurance premium payments are due to the District before my leave begins. If my approved leave extends beyond one calendar month, I may arrange a payment plan with the District. Under an approved payment plan, premiums for each upcoming month must be received no later than the first day of that month.

_____ **Return to Work:** I understand that I am expected to return to work on the approved return date listed above. If I am unable to return as scheduled due to unforeseen circumstances, I will notify the District as soon as possible and may request an extension of my leave by submitting a new Request for Leave of Absence form. Approval of any additional leave is at the discretion of the Superintendent. Failure to return to work or communicate with the District may be considered a voluntary resignation or job abandonment, consistent with District policy and applicable law.

_____ **Return-to-Work Requirements:** I understand that, before returning to work, I may be required to provide a release from my healthcare provider and/or successfully complete a Fit for Duty examination with a District-designated provider, if required by the District.

_____ **Duration of Leave:** I understand that when selecting my requested Return Date, I should allow sufficient time to complete any required return-to-work requirements, including obtaining medical clearance from my healthcare provider and/or completing a Fit for Duty examination. These requirements must be satisfied before I may return to work. If they are not completed by my approved return date, I understand that I may not be permitted to resume work until all required documentation and/or evaluations have been completed.

By signing below, I certify that I have read, understood, and agreed to all conditions outlined above regarding my request for personal unpaid leave.

Employee Signature: _____ **Date:** _____

CONDITIONS OF RETURN (to be filled out by HR):

This request for a Leave of Absence is: ☐ Approved ☐ Denied

Y / N – Applicant will be required to pay my monthly premiums to maintain insurance benefits during their leave. Applicant is responsible for paying \$_____ **per month for** _____ **months**; due on the 1st day of leave and the 1st day of the month after that. This amount will be paid to the Payroll Clerk at the District Office.

Y / N - As a condition of return, the Applicant is required to provide written release from their healthcare provider stating that they are medically able to return to work and perform the essential functions of their position.

Y / N – Applicant is required to successfully complete a Fit for Duty examination specific to the essential functions of their position. Once they have received medical clearance from their healthcare provider, Applicant will contact the HR Coordinator to schedule the examination with the District's designated occupational health provider, **St. Luke's Occupational Health Clinic** in Nampa. The District will pay the cost of the Fit for Duty examination.

Supervisor Signature: _____ Date: _____

Superintendent Signature: _____ Date: _____

Human Resources Signature: _____ Date: _____