LEAVE OF ABSENCE REQUEST

Name:_____ Date:_____

Campus:_____ Position: _____ Employee ID#: _____

Beginning Date of Leave: _____ Returning Date of Leave: _____

Check One ✓	***Reason for Absence***		***Documentation Necessary***	**Hardship Days** (office use only)
	Personal Medical Limited to medical leave necessary for employee illness.		note from doctor with applicable dates	
	Family Medical (FMLA) FMLA - for Employee or A Family Member Illness Medical leave (illness) within the employee's immediate family member or self - as defined by the Family Medical Leave Act. FMLA runs concurrently with other leaves You may be subject to get a Medical Certification completed if, applicable	***Date of Employment*** *(office use only)* ___/___/___	note from doctor with applicable dates for either the employee's need or the family members care needs	
	Maternity / Parental Leave Parental leave is available for employees who qualify for leave for adoptive or natural reasons. Days available may vary but in no case extend beyond leave provided under the Family Medical Leave Act.		note from doctor with applicable due date and medical recovery time	
	Military Service Employees required to serve in the federal or state military shall be granted leave. Short term state military or federal reserve military leave shall not exceed fifteen days per federal fiscal year.		Send copy of military orders to Leave Coordinator	N/A
	Religious The District shall reasonably accommodate requests for absences to participate in religious observations and practices.		will vary/contact Leave Coordinator	N/A
	Workers' Compensation (WC) All work-related injuries should be reported to the benefits office, If an employee will be absent from work for an extended period of time due to a work injury, employee's eligibility for FMLA will be reviewed for their leave absences.		will vary/contact Leave Coordinator	N/A
	Assault A District employee who is physically assaulted during the performance of regular duties is entitled to time necessary to recuperate from physical injuries sustained as a result of the assault.		will vary/contact Leave Coordinator	N/A

Employee Signature: _____ Date:_____

PLEASE RETURN FORM AND DOCUMENTATION TO EMPLOYEE BENEFITS AT YOUR EARLIEST CONVENIENCE:

By Mail
Benefits Office
PO Box 217
Lewisville, Texas 75067

By Fax
972-350-9359
By Email
estrada-ortegap@lisd.net

Inter-Campus Mail
Benefits Office

(For Benefits office use only)

Leave Coordinator Signature: _____ Date:_____

Eligibility Calculation **1250 worked in rolling period & employed for 12 months**	AB = _____ x _____ hrs = _____ Total HRS = Days worked prior school year ___ + Current year worked ____ = _____ Total hours worked:_____ - AB Hours ____ = Elig Hours _____ Worked 1250 hours: _____ Worked 12 months in rolling period:_____ DNQ ____