# LEAVE OF ABSENCE REQUEST

**Please complete this entire form and return it to your Office Manager. Leave status will be calculated and a copy sent to you. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE MANAGER AND MELISSA CANDELARIA LOA SPECIALIST AT THE INCEPTION AND OFFICIAL RETURN OF MY LEAVE.**

**NAME:** _____ **EMPLOYEE ID:** _____ **Phone Number** _____

**WORK LOCATION:** _____ **ESTIMATED DATE LEAVE TO BEGIN:** _____

**POSITION:** _____ **ESTIMATED DATE RETURN TO WORK:** _____

**DATE OF REQUEST:** _____ **NAME OF PRE-ARRANGED SUBSTITUTE (if applicable):** _____

**Request required for reasons below for absences 6 days or more.**

☐ ***MEDICAL LEAVE** (**Doctor's note must be attached)

☐ ***PARENTAL** (**Doctor's note must be attached)
(Earned Paid Time Off leave may be used for first 6 weeks from date of birth for medical purposes)
**Due Date**_____

☐ **WORKER'S COMPENSATION** (**Doctor's note must be attached)

☐ **FAMILY ILLNESS** (**Doctor's note must be attached)
List Relationship to employee _____

☐ **ADOPTION LEAVE**
(Earned Paid Time Off leave may be used for first 6 weeks from adoption)

☐ **MILITARY LEAVE**

****Failure to attach note may result in unpaid leave.**

☐ **I understand I must use any earned leave to cover the time of the leave when I am physically unable to work (up to 6 weeks from childbirth for maternity leave/ adoption or 8 weeks for a C-section).**

☐ **I understand for a Medical/Maternity Leave, Family Illness, Employee, Child, Spouse quarantine or Workman's Compensation - I must use leave available. Leave will be deducted as follows: Paid Time Off, Comp Time and Vacation.**

☐ **I understand for a Medical/Maternity Leave, Family Illness or Workman's Compensation- Failure to return Certification of Healthcare Provider within the allotted time may result in any absences not being designated as FMLA protected leave.**

I meet all guidelines listed below (which may allow my participation in **Family Medical Leave (FMLA)**:

1) Worked for CUSD for at least 12 months.
2) Worked at least 1250 hours during 12 months prior to the start of FMLA leave.
3) Have not taken 12 weeks of FMLA in the last 12 months.
4) I intend to return to work at the end of my approved leave of absence. YES ☐ NO ☐

***** *Employees on medical or maternity leave are expected to return to work upon full release from their physician. Prior to returning to work, you **must** submit a physician's release to your site Office Manager who will then forward a copy to the attention of your Human Resource Associate **a minimum of 2 days prior to your return. If released with restrictions, please contact HR for approval prior to reporting to work.***

Employee Signature – Signature indicates agreement to terms listed above. Date

Supervisor Signature Date