

APPLICATION FOR LEAVE OF ABSENCE

Name of Employee Requesting Leave of Absence

Current Address

First Day of Anticipated Leave of Absence

Anticipated Return to Work Date

Length of Proposed Leave of Absence

Reason for a Leave of Absence (Explain in Detail):

Name of Medical Care Provider (if applicable)

Office Address of Medical Care Provider (if applicable)

Phone Number of Medical Care Provider (if applicable)

Date of Medical Care Provider's Certification (if applicable)
Attach a copy of the Certification to this Application.

In requesting this Leave of Absence, and should my request be granted, I have been informed as follows:

1. If the leave is to care for my seriously ill spouse, son, daughter, or parent, or due to my own serious health condition, I must provide the District with a complete medical certificate within 15 days after the date of this leave request. I understand that if I fail to submit the certification within the 15-day period, the District may deny the taking of leave or deny the continuation of leave until the required certification is provided. The District may request additional certification if it has reason to question the appropriateness of the leave or its duration.
2. If the leave is due to my own serious health condition, the District may require a fitness-for-duty certification before I can be returned to work. If I fail to provide a fitness-for-duty certification, the District may deny me employment restoration until I submit such a certification.
3. If my leave is for a Family and Medical Leave Act ("FMLA") qualifying purpose, the District may require or I may elect to substitute paid vacation, personal, medical or sick leave days in place of the FMLA leave in accordance with the FMLA and the employer's leave policies.
4. If my leave is for an FMLA—qualifying purpose, my benefits under the District's group health plan will be continued for up to twelve work weeks. If paid leave is substituted in place of the FMLA leave, my share of the insurance premium will be paid through a payroll deduction. If my FMLA leave is unpaid, I must pay my share of the insurance premium to _____ and it must be received by on or before the _____ day of each month during the leave period.
5. If I fail to work after my FMLA leave has been exhausted or expires, the District may recover its share of the health plan premiums that it paid during the period of my FMLA leave.
6. On return from FMLA leave, I may be placed into the same position I held when the leave commenced or into an equivalent position with equivalent benefits, pay and other terms and conditions of employment.

Employee's Name (Please Print)

Employee's Signature

Date

The leave request will/will not be granted.

The leave will/will not be counted against the employee's annual FMLA entitlement.

The District reserves the right to change the designation of the leave to either FMLA or non-FMLA leave based on additional information provided by the employee during the leave period.

Approved By (Please Print)

Signature of Administrator

Date