A picture containing drawing

Description automatically generated **REQUEST FOR LEAVE FORM (L-1)**

MUST BE COMPLETED FOR ANTICIPATED ABSENCES OF MORE THAN TEN (10) CONSECUTIVE DAYS

Employee’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School/Dept: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type: Full Time Part Time

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

**I am requesting a leave of absence for the following length of time:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Leave Beginning (Required) Date Leave Ending Return Date (Required)

**RANK THE ORDER (1, 2, 3, ETC.) IN WHICH YOU WISH TO USE LEAVE:**

\_\_\_\_\_\_Sick Leave \_\_\_\_\_\_Annual Leave \_\_\_\_Bonus Leave \_\_\_\_\_\_\_\_\_Extended Leave (Teachers Only)

\_\_\_\_\_\_Personal Leave (Teachers Only) \_\_\_\_\_\_Voluntary Shared Leave (pending approval)

\_\_\_\_\_\_Leave without pay Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **an employee exhaust all accrued leave and “goes off payroll,” The employee will:**

**\*Be responsible for the payment of any Flex Benefits (i.e. dental, vision, supplemental insurance)**

**\*Be responsible for the payment of your employee premium/dependent health plan coverage and after the 12 weeks of approved FMLA has been exhausted, you will owe the entire cost of your health plan.**

**CHECK REASON FOR REQUEST** **(FORM WH-380E OR WH-380F IS REQUIRED PRIOR TO APPROVING FMLA LEAVE)**

□Family Illness (Immediate Family) □Pregnancy¹ (See note below)

□Personal Illness/Injury □Pre Birth Period

□Military Leave (orders required) □Post Birth Period

□Advanced Studies (Proof of Full-Time Enrollment) (6 weeks Normal Delivery/8 weeks C-section)

□Workers Compensation (Pending Approval) □Parental Leave/Care of Newborn

□Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Annual Leave, Personal Leave, LWOP)

□Adoption

***You will be required to present a Release to Return to Work for Personal Illness/Injury.***

¹Note: If you plan to add your child to your insurance, email [stephanieg.davis@bcsemail.org](mailto:stephanieg.davis@bcsemail.org) 60 days prior to due date

**Licensed Personnel:** I understand that taking a year leave may affect my time toward EXPERIENCE CREDIT, OR BEGINNING TEACHER (BT) CREDIT. A year for experience and BT credit is defined as 21.5 days per month for six (6) months (129 days) in active paid status.

**FAMILY and MEDICAL LEAVE ACT**

The Family and Medical Leave Act of 1993 (FMLA) allows eligible employees to take 12 workweeks of job protected leave (12 workweeks begin on the first day of the qualifying event) for their own serious medical condition or that of an immediate family member, even if the employee does not have accrued leave. In addition, the FMLA allows eligible employees to take the same job protected leave for the birth of a child or the placement of a child with the employee through adoption or foster care. The only stipulation to the FMLA is that the employee must have been employed with Buncombe County Schools for at least 12 months and have worked at least 1,250 hours in the previous year**. Employers must maintain employer paid health insurance benefits while the employee is on an approved FMLA leave.**

I have fully read and understand the Request for Leave Form and the FMLA statement. I also understand if any dates change, **I will immediately contact my payroll secretary at my school or department to verify the correct days and submit the necessary revised medical documentation.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Signature Date Principal/Supervisor’s Signature Date

**This leave of absence has the following effects:**

* You will continue to accrue leave as long you remain in active paid status.
* You will NOT earn sick/annual leave while you are in a non-active paid status.
* You will NOT earn exp credit on your license or in the Retirement System while you are in a non-active paid status.
* You may NOT earn Beginning TEACHER (BT) credit if you do not work a total of 129 days in this year.
* You may not receive the Local Supplement if you have been on leave in a non-active paid status.

**During this approved leave you may use:**

\_\_\_\_ Accrued Sick Leave \_\_\_\_Accrued Annual Leave \_\_\_\_\_Personal Leave \_\_\_\_\_Bonus Leave

\_\_\_\_Voluntary Shared Leave (if applicable) \_\_\_\_\_Extended Sick Leave \_\_\_\_Leave Without Pay

\_\_\_\_Trade Day \_\_\_\_\_\_Comp Time

**POST BIRTH PERIOD:**  Cannot Use Sick/Extended Leave Beyond \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cannot Use Voluntary Share Leave Beyond\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leave (hrs.) available as of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Revised: \_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sick: \_\_\_\_\_\_\_\_\_\_\_ Annual: \_\_\_\_\_\_\_\_\_\_\_\_\_ Revised: \_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal: \_\_\_\_\_\_\_\_\_\_\_ Bonus: \_\_\_\_\_\_\_\_\_\_ Revised: \_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Extended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CC: School/Dept. AP SD LW SH Payroll \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR HUMAN RESOURCE DEPARTMENT USE ONLY**

Your request for leave of absence has been: □Approved □ Denied □ Approved by Supervisor

Approved by HR Director or Designee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ You are eligible for benefits under the Family Medical Leave Act (FMLA). Your eligibility period for benefits begins \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and ends \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (12 weeks).

□ You are not eligible for FMLA benefits due to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_