REETHS-PUFFER SCHOOLS
LEAVE OF ABSENCE REQUEST FORM

Employee Name: _____ Date_____

Employment Position:_____ Building: _____

FMLA is an unpaid leave with up to 12 weeks of medical insurance coverage

☐ **FMLA PERSONAL MEDICAL LEAVE**
Serious Health Condition Leave – *Employee* (Physician Certification Required) -

☐ **FMLA FAMILY MEDICAL LEAVE**
Serious Health Condition Leave – *Family Member* (Physician Certification Required)
Leave is to care for: ( ) Spouse ( ) Child ( ) Parent

☐ **FMLA NEW CHILD LEAVE**
Date of birth or placement: _____

☐ **SICK LEAVE - EXTENDED MEDICAL LEAVE** (Paid time off using accumulated sick days)

☐ **MILITARY LEAVE** - Orders (documentation) of notice to appear for duty required.

☐ **UNPAID LEAVE OF ABSENCE**

Leave of Absence will begin :_____ **Expected Date of Return:**_____

Purpose of Leave:

_____
_____
_____
_____

A medical reason requires a doctor's slip indicating the start and expected return of the leave. Prior to your return you will be required to submit a signed release from your Doctor.

_____ _____
Date **Employee Signature**

_____ **LEAVE APPROVED** _____ **LEAVE DENIED**

Comments:

_____
_____
_____
_____

_____ _____
Date **Human Resources Signature**

Distribution: Human Resources Office, Financial Services, Employee, Union