

EMPLOYEE LEAVE REQUEST

Please complete this form within 2 working days of using any paid or unpaid leave.

EMPLOYEE NAME _____

DATE(S) OF ABSENCE	# OF DAYS (HALF or FULL)	TYPE OF LEAVE	NAME OF SUBSTITUTE
_____	_____	SICK LEAVE	_____
_____	_____	PERSONAL LEAVE (24 Hours Advance Notice)	_____
_____	_____	FAMILY ILLNESS Family Member (required): _____	_____
_____	_____	BEREAVEMENT Family Member (required): _____	_____
_____	_____	STAFF DEVELOPMENT	_____
_____	_____	SCHOOL BUSINESS/ACTIVITIES	_____
_____	_____	VACATION (PAID)	_____
_____	_____	LEAVE WITHOUT PAY	_____

PLEASE COMPLETE THIS SECTION IF APPLICABLE TO YOUR ABSENCE.

Please check one of the following:

- Your serious health condition (certification may be required) (OFLA/FMLA)
- Family members with serious health condition (certification may be required) (OFLA/FMLA)
- Child requiring home care (OFLA)
- Pregnancy (includes prenatal care, childbirth, and recovery) (OFLA/FMLA)
- Care for a newborn child (OFLA/FMLA)
- Placement/adoption of child or adult dependent (OFLA/FMLA)
- Parent-in-law with condition that poses imminent danger of death, is terminal or requires constant care (OFLA)

NOTE: In some instances it may be necessary for your employer to ask for additional information to determine whether the leave is OFLA/FMLA qualifying.

EMPLOYEE SIGNATURE _____ DATE _____

Confidentiality: Any disclosure of medical information will be kept in a confidential file and will be used only to determine eligibility for OFLA/FMLA and to track leave.

Approved Not Approved Supervisor's Signature _____ Date _____