REQUEST FOR LEAVE OF ABSENCE (5 days or more)

EMPLOYEE NAME: _____ LOCATION: _____

DATE LEAVE TO BEGIN: _____ (Estimated) DATE OF RETURN: _____ (Estimated)

☐MEDICAL LEAVE* ☐FAMILY ILLNESS* ☐ADOPTION LEAVE ☐MILITARY LEAVE ☐MATERNITY LEAVE
*Doctor's note must be attached

Baby Due Date: _____

I elect to use earned leave as follows:
NOTE: Personnel Absence Form must also be completed

Sick Leave: _____ hours Discretional Leave: _____ hours Vacation Leave: _____ hours
(Upon depletion of sick leave, 12 month employees only)

* Requirements for FMLA only
I request participation in **Family Medical Leave (FMLA)** based upon the guidelines listed below:

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

I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY THE SUBSTITUTE COORDINATOR AT THE INCEPTION OF MY LEAVE. I ALSO UNDERSTAND THAT I AM EXPECTED TO RETURN TO WORK UPON FULL RELEASE FROM MY PHYSICIAN. I WILL SUBMIT A PHYSICIAN'S RELEASE TO TARYN LOEHR, HR AND BENEFITS SPECIALIST, PRIOR TO MY RETURN.

_____ _____
Employee Signature Date

_____ _____
Supervisor's Signature Date

Please return completed forms to **Andrea Vasquez, HR Benefits Coordinator**.

FOR BENEFIT AND PAYROLL USE ONLY

WORK CALENDAR: _____

ESTIMATED PERIOD OF UNPAID LEAVE: _____

MEETS FMLA ELIGIBILITY: YES ☐ NO ☐
☐ FMLA LETTER SENT
☐ RECEIVED PHYSICIAN'S CERTIFICATION
☐ FMLA APPROVAL/DENIAL SENT