

Leave of Absence Form

I would like to request the following type of leave of absence (LOA):

_____ *Family Medical Leave of Absence (FMLA)
(Up to 12 weeks. Excludes 1st year employees)

I understand that I have to use **all** of my sick days before my FMLA will begin. The Board will continue to pay the allocation for my insurance. I will be responsible to pay my part of any PEEHIP insurance that I currently have as well as any other insurance premiums.

_____ Leave of Absence (with approval of Superintendent)
_____ Maternity Leave of Absence
_____ *Medical Leave of Absence
_____ Military Leave of Absence

I understand that the above leaves are taken **without pay**, sick days **do not have to be used** and if I want to keep my insurances I will be responsible for paying the **entire premium(s)**.

FYI: You will continue to receive a paycheck as long as you use sick days.

*Certification of medical leave may be requested.

I will begin my leave on _____, _____ *or*
approximately on _____, _____.

I plan to return to work on _____, _____.

Comments: _____

If you have any questions concerning a leave option, contact Franchesca Rivera at 549-2948.

Print Employee Name

School

Employee Signature

Position

Date

(1) copy to Superintendents office

(1) copy to Franchesca Rivera (Central Office Insurance Clerk)