



LEAVE OF ABSENCE REQUEST

Last First Middle Initial Social Security Number (last 4 digits)

Mailing Address City State Zip

() ()
Primary Phone Secondary Phone Email Address

Position Location/Department

Hours per week Days per week Days per year

LEAVE REQUESTED

Leave begin date Return to work date

I am selecting the following:

☐ Short-term leave without pay (6 days or less)

I am requesting a short-term leave without pay. I understand that I am not eligible for paid leave and have exhausted or will exhaust personal leave during this absence. I understand that my pay, job status, and benefits will be affected because of this leave and accept the responsibility.

☐ Long-term leave without pay (7 days or more)

I understand that to qualify for this leave, I must have been employed by the District for a minimum of twelve (12) months prior to the beginning of the leave. I understand that I have exhausted or will exhaust all personal leave during this absence. I understand that my pay, job status and benefits will be affected because of this leave and accept the responsibility.

PAY ADJUSTMENT

☐ Please process the pay adjustment in one lump sum

☐ Please spread the pay adjustment over _____ pay periods.

DESCRIPTION OF LEAVE

Please provide a brief description of the leave you are requesting.

ATTESTATION

My signature below confirms that I am requesting a leave of absence as stipulated above and understand I will be expected to return to work once the approved leave time has concluded. I also understand that my salary and benefits are impacted by this leave. *Please refer to your specific CBA for any additional information regarding the impact of taking a leave of absence.*

Employee Signature Date

APPROVALS: *Signature of supervisor required prior to submitting to Human Resources*

Supervisor Director of Human Resources

OFFICE USE ONLY

☐ HR _____ ☐ Payroll _____ ☐ Date to Board: _____