Request for Leave of Absence Form

IF THE EMPLOYEE IS TO BE ABSENT FOR ELEVEN (11) DAYS OR MORE, THIS FORM IS REQUIRED

EMPLOYEE INFORMATION

Employee Name (First, Middle Initial, Last Name)

Home Address	**City**	**State**	**Zip**

Employee ID Number	**Telephone Number** ☐ HOME ☐ CELL
Site:	**Position:**

ABSENCE INFORMATION

☐ **Initial Application** ☐ **Extension Request**	**Requested Start Date:**	**Anticipated Return Date:**

TYPE OF LEAVE

Are you requesting an Intermittent leave? ☐ Yes ☐ No	**Is this a work-related illness/injury?** ☐ Yes ☐ No

REASON(S) FOR LEAVE

Please indicate the applicable reason(s) for your leave below. If you require additional information about leave types and their qualifying criteria, please visit the HR webpage or contact Ms. Hayden at Haydensa@orange.k12.nj.us. or Ms. Masoud at Masoudna@orange.k12.nj.us

- ☐ Employee's own serious health condition
- ☐ Care for an ill parent, spouse, or child
- ☐ Birth of a Child/Adoption
- ☐ Other (Please explain and attach to application w/ supporting documentation)
- ☐ Study/Training/Education
- ☐ Military Service
- ☐ Qualified military exigency parent/spouse/Child
- ☐ Care for covered military service member

For leaves due to your own or a family member's serious health condition, an FMLA form is required and MUST be filled out.

- ☐ A completed FMLA (*WH-380E/F) form* is attached.
- ☐ I will submit a FMLA (*WH-380E/F) form* within 5 days to the Benefits Office.
- ☐ A physician or care provider note on their letterhead is attached.
- ☐ I will submit a physician or care provider note on letterhead within 5 days.

HR will verify your FMLA eligibility and notify you as applicable. If your leave request does not qualify for FMLA, it will be reviewed and approved for another leave type and will be determined in accordance with the Governing Board Leave Policy.

DAYS REQUESTED AND REQUIRED DOCUMENTS

You may use your accrued time (PTO and vacation) during Medical/FMLA leave. **If you opt** to use accrued time, please indicate below how many days you wish to use.

I wish to use _____sick days I wish to use _____personal days ____I do not wish to use my accrued time

Please initial each section below:

____I understand that I am to report my absences to Absence Management until the HR/Benefits Department has cleared me.

____I understand that if I qualify for FMLA leave, I will be required to submit a *Medical Certification* from my Health Care Provider to the HR/Benefits Office. Failure to complete the necessary forms may result in a delay or prevent leave approval.

____If on medical leave, I understand that I *MUST* provide the HR/Benefits Department a *Return-to-Work Authorization* from my physician at least 2 days *PRIOR* to my return. I CAN NOT report work until the HR/Benefits department has cleared me.

____If I am unable to return to work on my anticipated return date, I understand that I must request an extension 5 days prior to my revised return date.

___I understand that any benefits I may have can continue as long as I remain in a paid status. If I go into an unpaid status while on FMLA, I will make financial arrangements with the Business Office to continue payment of my portion of the premiums. If I go into an unpaid status and a m ineligible for FMLA, my benefits will terminate at the end of the month in which my accrued leave is depleted and I will be offered COBRA.

____ I understand that I must be in a paid status five (5) days prior to any school closing/break to receive compensation during the closed period.

Employee Signature: Date:	Administrator Signature: Date:
	HR Executive Director Signature: Date: