



LEAVE OF ABSENCE REQUEST

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

Mailing Address City State Zip

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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 my pay, job status, front loaded leave and benefits will be affected and prorated 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 my pay, job status, front loaded leave and benefits will be affected and prorated 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, front loaded leave, 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: _____