

**APPLICATION FOR LEAVE OF ABSENCE CERTIFICATED**

**SCHOOL-LEVEL**

**EMPLOYEES**

*Distribution:* ***Leave with Pay (Teachers):*** *1. Original - School; 2. Copy 1 - Employee; 3. Copy 2 - PRO (if leave exceeds one month) /* ***Leave With Pay (EOs):*** *1. Original - School; 2. Copy 1 - Employee /* ***Leave Without Pay and Military Leave With Pay:*** *1. Original - OHR, Records and Transactions Section, Certificated;*

*2. Copy 1 - Employee; 3. Copy 2 - School; 4. Copy 3 - PRO; 5. Copy 4 - Payroll Office, Leave Accounting Section*

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**I. EMPLOYEE INFORMATION**

Name: Last 4 digits of SSN:

Last First M.I.

Address: City: State: Zip: Tel#: Position: School/Office: School or Sub-Division Code: \_ \_ \_ Leave Code: \_ \_ \_ Bargaining Unit Code: \_ \_

1. **LEAVE REQUEST (Complete appropriate subsection below.)**

Family 1 Military 4 Political 5 Other:

Funeral 2 Personal Sick 3

Health, LWOP 3 Personnel Development Vacation

1 Complete and attach Federal Form [WH-380F](http://www.dol.gov/whd/forms/WH-380-F.pdf) or [WH-380E(Sde)](http://www.dol.gov/whd/forms/WH-380-E.pdf). 2 Provide relationship to deceased and address if out of state in

3 Complete Licensed Physician's Statement by completing Section IV #2 below.

at bottom of this form for Health leave or if Sick leave for more 4 Attach a copy of your military orders with this form (copy) to than five (5) consecutive days or submit a signed doctor's note OHR, Records and Transactions Section, Certificated. verifying current health condition. Approval for sick leave is 5 Attach a separate letter justifying political appointment.

subject to the availability of accumulated sick leave.

I hereby request the following type of leave: Leave with Pay Leave without Pay for the calendar period below: From: To:

MM/DD/YYYY MM/DD/YYYY # of working days

* 1. Is this an extended leave? Yes No
  2. Provide any additional explanation for leave request (attach a separate sheet if necessary):

Employee Signature: Date:

MM/DD/YYYY

**III. LEAVE APPROVAL**

For sick, vacation, and personal leave, Principal/Immediate Supervisor approval required.

For family, military, personnel development, and political leave,**both** Principal/Immediate Supervisor **and** PRO/CAS approval required.

Approved Principal/Immediate

Not Approved Supervisor Signature: Date:

MM/DD/YYYY

Approved

Not Approved PRO/CAS Signature: Date:

MM/DD/YYYY

**IV. LICENSED PHYSICIAN'S STATEMENT**

**(To be completed ONLY for HEALTH LEAVE or if SICK LEAVE is for more than five (5) consecutive work days)**

I certify that is under my care for health reasons and is not physically able to perform his/her normal work duties from to .

MM/DD/YYYY MM/DD/YYYY

Licensed Physician Signature: Date:

MM/DD/YYYY

Name of Licensed Physician (Print): Type of Practice: Address: Tel#: