Request Form for Extended Leave of Absence

Employee's Illness/Family Member's Illness

Name: _____ Date: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone/Voice Mail: _____

Email: _____@**wls4kids.org** Personal Email Address: _____

Position/Grade: _____ Building/Dept._____

1. I am requesting a Leave of Absence for:

☐ **My own illness or serious health condition** that makes me unable to perform the function of my position.

☐ **To care for an immediate family member** who has a serious health condition requiring my assistance.
Family member's relationship to employee: _____

2. Method of leave requested:

☐ Consecutive leave. Estimated date leave will begin: _____ Return to work on: _____

☐ Intermittent or reduced schedule leave (specify schedule below) Date beginning: _____

_____

- Submit a Health Care Providers Certification form or other documentation from a health care provider within 15 days of this original request to certify your need for an extended absence/leave from work.
- If the absence/leave is for your own illness, submit a doctor's notice to the Human Resources Office clearing your to return to work before you return.
- Notify the Human Resources Office promptly of any changes in the estimated dates listed above.
- You must use accumulated sick, personal, vacation and/or compensatory time as allowed by collective bargaining agreements before using any unpaid leave. If the leave qualifies for FMLA, the paid days will be counted against your FMLA entitlement.
- For questions about your accumulated leave days and health insurance coverage during this leave contact:

Classified Payroll	Beckie Richards	ext. 7004	brichards@wls4kids.org
Certified Payroll	Brenda Lettman	ext. 7007	blettman@wls4kids.org
Insurance Info. and IT Payroll	Dianna Myers	ext. 7005	dmyers@wls4kids.org
Human Resources	Laura Berryman	ext. 8225	lberryma@wls4kids.org

Employee Signature: _____ Date: _____

Is leave request approved? ☐ YES, qualified for FMLA

☐ YES, but NOT FMLA Explain: _____ ____

☐ NO, Explain: _____

Authorized Signature: _____ Date: _____

Washington Local Schools Human Resource Office, 3505 W. Lincolnshire Blvd., Toledo, OH 43606
Fax: 419-407-4004 Phone: 419-473-8225 Email: lberryma@wls4kids.org

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Office Use Only.

Long term sub assigned: _____

Health Care Provider's Certification form received: (date) _____

Doctor's release to return to work received (date) _____ Schedule of paid/unpaid days:

_____ through _____ = _____ PAID (____ sick ____ pl ____ vac)

_____ through _____ = _____ UNPAID ON Board agenda (date) _____

Last day of district paid insurance (if applicable): _____ COBRA? ____yes ____ no

cc: Employee, Payroll (2), Benefits, Principal/Director, Substitute Office, HR Director, File **Revised 07/2018**