Blackhawk School District

Request for Leave of Absence

Please forward a hard copy of this form to your building principal.
Please return completed form to the Superintendent's Secretary.

NOTE: When the need for leave is foreseeable, you must give notice 30 days in advance.

Employee Name:_____ Date of Request:_____ Date of Hire:_____

Home Phone:_____ Cell Phone:_____ Part Time ◯ Full Time ◯

REASON(S) FOR LEAVE REQUEST:

Child bearing. Estimated delivery date:_____
Child rearing. (Post child bearing or adoption).
Care of child, spouse, or parent. Please attach medical certification and proof of relationship.
My own health. Please attach medical certification.
Military duty or training. Please attach orders.
Personal. Please explain:_____

DURATION OF LEAVE:

Requested start date of leave:_____ Expected return to work date:_____

Total work days requested:_____ I plan to use (specify number of each): _____ Sick days _____ FMLA days _____ Unpaid days

I request intermittent FMLA leave or a reduced schedule leave as follows:_____

I UNDERSTAND AND AGREE TO THE FOLLOWING:

I agree not to take another position or be self-employed during this period.
If my leave does not qualify under the Family and Medical Leave Act (FMLA), Board policy and collective bargaining agreements will determine employment. If this request qualifies as a leave under the FMLA and I return to work within the time available to me under FMLA, I will be restored to my same or an equivalent position.
If intermittent leave or a reduced schedule leave is requested under FMLA, I may be transferred temporarily to an alternative position in order to accommodate my request.
District policy requires that medical certification be provided within 15 calendar days if the leave is taken for any of the following reasons:
To care for a family member with a serious health condition.
An employee's own serious health condition (including intermittent or reduced scheduled leaves under FMLA).
If I do not provide medical certification as requested, my absence will be governed by the District's attendance policy.
If the leave is due to my own serious health condition, "Return to Work" certification will be required prior to returning to work.
Failure to contact my supervisor within 48 hours of receiving "Return to Work" certification may result in termination.
I will contact my supervisor to advise of my intentions and progress of a monthly basis.
The expiration date of any corrective action in effect at the time of my leave will be adjusted upon my return.
District benefit accruals will be suspended during the unpaid (non-FMLA) leave and will resume upon return of active employment.
In order to continue my benefits while on unpaid (non-FMLA) leave, I must ensure premium payments are received by the first day of each month.
A 30-day grace period applies to all premium payments, after which coverage will be ended.
It is my responsibility to contact the Business Manager with any questions I may have.

Employee Signature:_____ Date:_____

Supervisor Signature:_____ Date:_____

**********For Business Office Completion**********

Type of leave requested: ____FMLA Medical ____FMLA Family ____Personal Medical ____Personal Other ____Military

Leave request is approved to begin on _____and return on _____

Leave request is denied for the following reason:_____