

APPLICATION FOR LEAVE

NAME: \_\_\_\_\_ EMPLOYEE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_  
 JOB TITLE: \_\_\_\_\_ WORK LOCATION: \_\_\_\_\_

*I HEREBY APPLY FOR APPROVED LEAVE AS LISTED BELOW.*

- |   |        |        |
|---|--------|--------|
| <input type="checkbox"/> PAID LEAVE:                | # DAYS |        |
| <input type="checkbox"/> ACCUMULATED SICK DAYS: (1) | _____  |        |
| <input type="checkbox"/> VACATION LEAVE:            | _____  |        |
| <input type="checkbox"/> PERSONAL LEAVE:            | _____  |        |
| <input type="checkbox"/> FLEX LEAVE:                | _____  | (F)    |
| <input type="checkbox"/> PROFESSIONAL LEAVE: (3)    | _____  | (P)    |
| <input type="checkbox"/> MILITARY LEAVE: (4)        | _____  | (M)    |
| <input type="checkbox"/> LEGAL LEAVE: (5)           | _____  | (S, J) |
| <input type="checkbox"/> BUSINESS: (6)              | _____  | (B)    |
| <input type="checkbox"/> BEREAVEMENT (Sick Days)    | _____  |        |

- |  |        |
|--|--------|
| <input type="checkbox"/> UNPAID LEAVE:             | # DAYS |
| <input type="checkbox"/> EXTENDED SICK LEAVE: (2)  | _____  |
| <input type="checkbox"/> PROFESSIONAL LEAVE: (3)   | _____  |
| <input type="checkbox"/> EMERGENCY LEAVE:          | _____  |
| <input type="checkbox"/> LEGAL LEAVE: (5)          | _____  |
| <input type="checkbox"/> MATERNITY / NEWBORN CARE: | _____  |
| <input type="checkbox"/> OTHER: _____              | _____  |
| _____  | _____  |
| _____  | _____  |

- (1) ACCUMULATED SICK DAYS: (Over **10 consecutive** work days off sick. Statement from doctor is required and should be attached)  
 (2) EXTENDED SICK LEAVE: (Statement from doctor is required and should be attached)  
 (3) PROFESSIONAL LEAVE: (List in comments the conference, activity or event to be attended. Job function does **not require** attendance)  
 (4) MILITARY LEAVE: (Attach copy of military orders)  
 (5) LEGAL LEAVE: (Attach subpoena or juror notification. Plaintiffs or defendants are **not** eligible for **paid** leave)  
 (6) BUSINESS: (List in comments where the employee is assigned or the job related meeting. (Attendance is required or recommended by supervisor)

FROM (Date): \_\_\_\_\_ Through (Date): \_\_\_\_\_ Total # Days: \_\_\_\_\_

REASON: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If meetings to be attended require additional Board expense, approval is required by your supervisor and if the expense is over \$600 then Board approval **IS** required. A Form B-3044 must be submitted for approval.

\_\_\_\_\_  
 Employee's Signature

\_\_\_\_\_  
 Signature of Principal,  
 Supervisor or Department Head

\_\_\_\_\_  
 Division of Human Resources

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Date

APPROVED  DISAPPROVED  APPROVED  DISAPPROVED

Substitute Requested:  NO  YES  Substitute Not Authorized at Board's Expense

27 digit account # \_\_\_\_\_  Substitute Provided at Board's Expense

**INSTRUCTIONS:** Vacation, Personal, Flex and Staff Development leaves may be approved by the supervisor. For approval of Extended Sick Leave and other leaves of absence, send one (1) copy to Human Resources.

**NOTE TO SUPERVISORS:** Attach one (1) copy of approved form to the appropriate payroll, one (1) to file, and one (1) to employee.

**MOBILE COUNTY PUBLIC SCHOOL SYSTEM  
FAMILY MEDICAL LEAVE ACT  
CERTIFICATION OF PHYSICIAN OR PRACTITIONER**

Employee Name: \_\_\_\_\_

\*Patient's Name (if other than Employee): \_\_\_\_\_  
Relationship to Employee: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Dates of Absence from work for this condition: \_\_\_\_\_  
(If maternity leave, please list estimated due date)

Probable Duration/Return to work: \_\_\_\_\_

Treatment Prescribed: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

.....  
For certification **RELATING TO ILLNESS OF THE EMPLOYEE**, please complete the following:

1. Is in-patient hospitalization of the employee required?       YES       NO
2. Is employee able to perform work of any kind?       YES       NO  
(If "NO", skip next question)
3. Is employee able to perform the functions of his/her job?       YES       NO  
(Answer after reviewing statement from employer of essential functions of employee's position, or, if not provided, after discussing with employee)

.....  
\*For certification **RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER** (parent, child, etc.), please complete the following as they apply to the family member:

1. Is the employee's presence necessary/beneficial for the care of the patient?       YES       NO
2. Probable duration of the need for employee's presence: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician or Practitioner**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**(Type or Print Name of Physician)**

\_\_\_\_\_  
**Address**

**Professional Organization:** \_\_\_\_\_

.....  
**TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY MEDICAL LEAVE**

When Family Medical Leave is needed, please state the reason you will be absent and the estimated time period:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

-----**PLEASE RETURN via FAX, EMAIL or MAIL TO:**-----

Fax: (251) 221-6237

Jaalyn McMillian: jamcmillian@mcpss.com or (251) 221-4542 (Last Names A-L and all of Central Office)

Angel Young: ahyoung@mcpss.com or (251) 221-4528 (Last Names M-Z and all of Transportation)

MCPSS - Human Resources, Employee Relations, P. O. Box 180069, Mobile, AL 36618



# FAMILY MEDICAL LEAVE ACT

## NOTICE OF ABSENCE FOR MEDICAL REASONS

\_\_\_\_\_

Date

I am requesting medical leave in accordance with Board Policy. My principal/supervisor and I have agreed that my absence will begin on \_\_\_\_\_.

My last day of work will be on \_\_\_\_\_. Please note that a completed Physician's statement should be attached.

\_\_\_\_\_ I wish to take my accumulated sick leave.

\_\_\_\_\_ I plan to request assistance through the Sick Leave Bank (Loan or Catastrophic Donation). An ***Application for Loan*** Packet **must also be submitted** to Human Resources for approval.

\_\_\_\_\_ I **DO NOT** wish to use my accumulated sick leave days. (***Form HR-124*** should be attached with your submission of this form).

I intend to return to my current position on \_\_\_\_\_ if my physician permits me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
School/Department

\_\_\_\_\_  
Position

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Mobile County  
PUBLIC SCHOOLS

# FAMILY MEDICAL LEAVE ACT CONFIDENTIAL INFORMATION RELEASE

I, \_\_\_\_\_, hereby give permission to the Division of  
Human Resources, Mobile County Public Schools, to discuss my medical condition with:

Dr. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

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## SICK, MATERNITY/PATERNITY LEAVE

If any employee is absent from work for more than ten consecutive workdays: he/she or an immediate family member must provide a physician's statement or legal documentation which verifies sickness, disability, birth or adoption of a child and apply for a leave of absence. Should circumstances (such as, but not limited to, frequent or excessive absences) warrant it, a supervisor may require a physician's statement or legal documentation for any absence.

### **Tenured And Non-Probationary Full Time Employees**

All tenured and non-probationary full time employees are eligible for the following leaves of absence. The first twelve weeks of these leaves of absence will be credited as Family Medical Leave Act (FMLA) coverage.

1. Sick Leave: Up to one year from the date of disability (as defined in Alabama Code - §16-1-18.1).
  - a. The employee must apply for a leave of absence by filling out form HR-124 and submit it along with the proper medical documentation covering the period requested on the leave request.
  - b. Should the employee be medically cleared to return to work within three weeks of the end of a school quarter, that employee may be required to remain off work until the beginning of the next quarter.
  - c. These leaves of absence may be in a paid status if Accumulated Sick Days are available or they may be in an unpaid status.
  
2. Maternity/Paternity Leave: Up to one year from the initial date of disability or birth/adoption of a child, whichever is earlier.
  - a. If any employee requests a maternity/paternity leave, he/she must apply for a leave of absence by filling out form HR-124 and submit it along with the proper medical or legal documentation that verifies the birth or adoption of a child covering the period requested on the leave request.
  - b. For maternity/paternity leaves of absence, the employee must state on the HR-124 the beginning and ending dates requested.
  - c. Due to the issues of long-term substitutes, employees will not be returned from a maternity/paternity leave of absence prior to the expiration of the requested ending date.
  - d. Should the employee request to be cleared to return to work within three weeks of the end of a school quarter, that employee may be required to remain off work until the beginning of the next quarter.
  - e. Except for the above example, maternity/paternity leaves will not be extended beyond the originally requested ending date or one year from the beginning date of the leave, whichever is earlier.
  - f. Except for any period of medically documented disability, maternity/paternity leaves of absence shall only be in an unpaid status.

### **Non-Tenured And Probationary Full Time Employees**

Non-tenured and probationary full time employees, if eligible in accordance with the Family Medical Leave Act, may be granted a leave of absence up to twelve (12) weeks.

### **Period of Leave**

The total period, at any one time, a tenured or non-probationary employee is allowed to take for a leave of absence is limited to twelve (12) months. If eligible for FMLA coverage, the total period, at any one time, a non-tenured or probationary employee is allowed to take for a leave of absence is limited to twelve (12) weeks. If not eligible for FMLA coverage, a non-tenured or probationary employee is not allowed to take a leave of absence. Any employee remaining off beyond these time limitations will have to resign, retire (if eligible) or be recommended for termination.

### **Miscellaneous Provisions**

An employee who fails to apply for sick or maternity/paternity leave as outlined in this policy shall be considered to have abandoned his/her job and may be recommended for termination.

Failure to provide proper documentation may result in denial of the leave of absence and if the employee does not report to work, he/she shall be considered to have abandoned his/her job and may be recommended for termination.

An employee who fails to return to work after the expiration of any period of leave (without approval of an extension of the leave) shall be considered to have abandoned his/her job and may be recommended for termination.

Employees are not allowed to work during any leave of absence in which a physician or mental health provider certifies disability. For maternity/paternity leaves, employees are not allowed to work unless it is part time work outside their normal working hours. However, this would not apply to a part time job at night or on the weekend. Violators will be considered to have abandoned his/her job since they are working elsewhere when they could be working for the school system and may be recommended for termination.

Reference: US Code - Title 29, Chapter 28 (Family and Medical Leave)

Reference: Alabama Code - §16-1-18.1 (Accumulation of Sick Leave)

Resource: Family Medical Leave Act Advisor

Resource: U.S. Department of Labor Employment Law Guide: Chapter 1 – Family Medical Leave Act

Adopted: February 26, 2008