

LEAVE OF ABSENCE REQUEST

Please complete this entire form and return it to your admin or supervisor. Leave status will be calculated and a copy sent to you. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY MY SUPERVISOR AND HUMAN RESOURCES AT THE INCEPTION AND OFFICIAL RETURN OF MY LEAVE.

NAME: _____ EMPLOYEE ID: _____ Phone Number _____

WORK LOCATION: _____ ESTIMATED DATE LEAVE TO BEGIN: _____

POSITION: _____ ESTIMATED DATE RETURN TO WORK: _____

DATE OF REQUEST: _____ NAME OF PRE-ARRANGED SUBSTITUTE (if applicable): _____

Request required for reasons below for absences 6 days or more.

***MEDICAL LEAVE** (**Doctor's note must be attached) **FAMILY ILLNESS** (**Doctor's note must be attached)

***PARENTAL** (**Doctor's note must be attached)
(Earned Sick Leave leave may be used for first 6 weeks from date of birth for medical purposes)
Due Date _____

ADOPTION LEAVE
(Earned Paid Time Off leave may be used for first 6 weeks from adoption)

I have **short-term disability** and would like to use it for my leave. (*requires additional paperwork)

WORKER'S COMPENSATION (**Doctor's note must be attached)

I would like to **request donated sick leave** (*requires additional paperwork)

I understand I must use any earned leave to cover the time of the leave when I am physically unable to work (up to 6 weeks from childbirth for maternity leave/ adoption or 8 weeks for a C-section). This does not apply if using the Short-Term disability benefit.

I understand for a Medical/Maternity Leave, Family Illness, Employee, Child, Spouse quarantine or Workman's Compensation - I must use leave available. Leave will be deducted as follows: Sick Time then Vacation. This does not apply if using the Short-Term disability benefit (if applicable).

I understand for a Medical/Maternity Leave, Family Illness or Workman's Compensation- Failure to return Certification of Healthcare Provider within the allotted time may result in any absences not being designated as FMLA protected leave.

**Failure to attach note may result in unpaid leave.

I meet all guidelines listed below (which may allow my participation in **Family Medical Leave (FMLA)**):

- 1) Worked for LWCS for at least 12 months.
- 2) Worked at least 1250 hours during 12 months prior to the start of FMLA leave.
- 3) Have not taken 12 weeks of FMLA in the last 12 months.
- 4) I intend to return to work at the end of my approved leave of absence.

YES NO

Employees on medical or maternity leave are expected to return to work upon full release from their physician. Prior to returning to work, you **must submit a physician's release Human Resources via email: hr@lwcharterschools.com **a minimum of 2 days prior to your return. If released with restrictions, please contact HR for approval prior to reporting to work.***

Employee Signature – Signature indicates agreement to terms listed above. Date _____

Supervisor Signature Date _____