



**LEAVE OF ABSENCE APPLICATION**

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

Position: \_\_\_\_\_ Building/Work Location: \_\_\_\_\_

Type of Leave Requested: Medical/Family Illness  Personal  PFML  Other

*FMLA cannot be approved without receiving the "Certification of Physician or Practitioner" form.*

Please state reason for leave request: \_\_\_\_\_  
\_\_\_\_\_

Date(s) of proposed leave: →First work day missed: \_\_\_\_\_

→First day back at work: \_\_\_\_\_

Will sick leave be used? YES  NO  How many days? \_\_\_\_\_

*If using more than five consecutive sick leave days, you must attach a doctor's statement of illness to this form. A doctor's release may be required prior to return to work.*

How many unpaid days? \_\_\_\_\_

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



Action needed for replacement: \_\_\_\_\_

Building Action: Approved  Denied  Date: \_\_\_\_\_

Doctor's Note Attached? Yes  No  \_\_\_\_\_

**Principal/Supervisor Signature**



Please send the completed form to Human Resources

District Office Action: Approved  Denied  Date: \_\_\_\_\_

Modified (Explain): \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Human Resources District Administrator**