



Request for/Notification of Leave of Absence

Name: _____ Position: _____ Site: _____

Leave dates: Anticipated last day of work: _____ Anticipated first day back: _____

Types of leave:

___ Unpaid Leave (approval needed): ___ Personal ___ Education ___ Sabbatical

Administrator: _____ Approved ___ or Denied ___

___ Family and Medical Leave Act (FMLA): ___ 5 weeks or less **or** ___ over 5 weeks

(Attach doctor's note. See bargaining agreement for details and more information)

___ Personal serious health condition that makes employee unable to perform the essential functions of their job.

___ To care for a spouse, child or parent who has a serious health condition.

___ Maternity/Paternity/Family Care: (Check all that apply)

___ Family and Medical Leave Act (FMLA)* (up to 12 weeks) (Maternity)

___ California Family Rights Act (CFRA) (up to 12 weeks) (Maternity/Paternity/Family Care)

___ Unpaid leave in addition to FMLA and CFRA (needs approval) (Mat/Pat/FC)

Administrator: _____ Approved ___ or Denied ___

Other information: _____

Sign: _____ Date: _____

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Leave Balances (in days): ___ Sick (___ Personal Necessity) ___ Personal Leave ___ Vacation (if applies)

Doctor's Note: ___ Note Received ___ Not Applicable

Substitute: ___ Short Term (<5 wks) ___ Long Term (>5 wks) ___ Temp (+90 days) ___ No Sub

Forms to be completed: ___ WH-380-E (doctor form) ___ WH-381 (eligibility form)

Request received by: _____ Date received: _____

Administrator: _____ Board notification/approval date: _____