



Request for Leave of Absence

Name of Employee: _____

Date: _____

Site: _____ Certification of Health Care Provider attached or provided within 15 days

1. Type of Leave Request

Check all applicable boxes of leave you are requesting:	Begin Date	End Date
<input type="checkbox"/> Temporary Disability Leave (FMLA/CFRA, 12 weeks max)		
<input type="checkbox"/> Work Related Injury/ Illness (60 days total)		
<input type="checkbox"/> Pregnancy Disability Leave (4 weeks prior, 6 weeks after) Estimated due date: _____		
<input type="checkbox"/> Parental Leave (60 days total, 50% pay)		
<input type="checkbox"/> Unpaid Leave (EC 44963, EC 45190)		
<input type="checkbox"/> Military Leave		
<input type="checkbox"/> Family Member Illness Leave (FMLA/CFRA, 12 weeks max)		
<input type="checkbox"/> Other: (Bereavement/Jury Duty, Etc.)		

2. Reason for Requesting Leave _____

3. Leave Duration (*please check one*)

Full absence during leave period (*dates noted above*)

Reduced work schedule during leave period (*please explain*) _____

Intermittent absences during leave period (*please explain*) _____

4. I HAVE READ THE NOTICE ON THE OTHER SIDE OF THIS FORM. Please submit these forms to the District Office 30 days prior to your leave commencing. You will receive additional information on the specific type of leave you are requesting along with approval/denial status and leave coordination pay information once this has been processed.

5. Employee Signature _____

DISTRICT OFFICE USE ONLY				
Request Sent: _____	Request Recv'd: _____	Certification Recv'd: _____	Approved <input type="checkbox"/>	Denied <input type="checkbox"/>

PREGNANCY DISABILITY (PDL), FAMILY AND MEDICAL LEAVE (FMLA/CFRA), MEDICAL LEAVE OF ABSENCE NOTICE

Notice to the employee: If the leave you are requesting meets the federal Family and Medical Leave Act and the state of California Family Rights Act (hereinafter referred to as "FML") requirements, you should be aware of the following rights and obligations:

The period of this leave will be counted as FML in determining your future eligibility for additional FML.

If your leave is due to a serious health condition (either your own, your spouse's, parent's, child's, or domestic partner), you must provide medical certification. Approval of your leave may be withheld until you comply with certification requirements. Prior to returning to work, you will be required to present a physician's certification of your ability to return to work if the leave is due to your own health condition.

It is the employee's responsibility to ensure the District receives medical certification. It is the employee's responsibility to ensure they return to work on the leave end date or provide medical certification to extend leave if necessary. It is the employee's responsibility to communicate any changes of the originally requested leave to the District.

Your accumulated sick leave and vacation time (if a classified employee) will be applied before placing you on unpaid leave of absence. Use of such paid time will not extend the amount of leave available.

For the period of FML, up to a maximum of 12 weeks in a 12 month period, the Lakeport Unified School District (LUSD,) will continue to pay its portion of your medical, dental and vision premiums. You will be required to pay any employee premiums (if applicable) during unpaid leave. If you wish to discontinue medical, dental and vision coverage during the unpaid leave, you may reinstate it upon return.

If you do not return from FML, LUSD may require you to reimburse it for medical premiums it paid on your behalf during the unpaid portion of your leave. However, no reimbursement will be required if you do not return because of a serious health condition or if you are unable to return due to circumstances, which are outside of your control.

Upon your return to work, you have the right to reinstate the same position or another position with equivalent benefits, pay and conditions of employment. If your job is unavailable due to, for example, a temporary or indefinite layoff, you have no greater right to reinstatement than if you were actively at work rather than on leave. Leave of absence will only be used for the period of disability resulting from a medical condition. If you do not return to work at the end of, or before, the completion of the period granted, or accept employment elsewhere while on leave, LUSD will consider this to be a voluntary resignation of your LUSD position.

Time spent on a medical leave will count toward the 12 weeks, in a 12-month period (beginning with initial FML eligibility,) allowed under the FML.

LUSD cannot guarantee any position beyond your approved leave period. Once you have exhausted all available forms of paid and unpaid leave, you will be placed on a 39-month rehire list (permanent employees only) or separated from service (probationary employees). Medical leaves due to pregnancy disability are up to four months, which do not run concurrently with the California Family Rights Act. Therefore, in certain cases, reinstatement may be granted up to seven (7) months.

Insurance coverage by LUSD will cease for time exceeding the paid period of disability unless payment of the premiums is made on a monthly basis by the employee.

Should this policy conflict with current prevailing law, prevailing law will apply.

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