Danville Community Consolidated School District No. 118

LEAVE REQUEST FORM

Employee's Name : _____

School: _____ **Assignment:** _____ **Date of Request:** _____

Leave Requested- Check all that apply. Please include beginning and ending dates for each type of leave requested.

(Leave descriptions are not intended to replace contract language. See group-specific contract, agreed-upon language, or Board Policy for specific leave information.)

_____ **Sick Leave**- A paid leave that may be used by an employee for personal illness or for serious illness or death for members of the immediate family as defined by contract language. **Doctor's certification required within 15 days of first day's absence.**

Anticipated Beginning Date: _____ Anticipated Ending Date: _____

_____ **Childbirth/Recovery Leave-** Childbirth/Recovery is classified as a temporary disability. Leave is up to six weeks (eight weeks if delivery by cesarean) after giving birth. A maximum of six to eight weeks of sick leave can be used for this leave. Any absence beyond this will be without pay, unless dictated by doctor's orders, and will require a separate Leave form. **Doctor's certification required within 15 days of first day's absence.**

_____ I wish to use the allowed sick time that I have available

Anticipated Beginning Date: _____ Anticipated Ending Date: _____

_____ **Family Medical Leave Act (FMLA)**- A leave for up to 12 weeks in a year that can be used for a serious medical condition of the employee or the employee's spouse, child, or parent, and for the birth or adoption of a child. All benefits, except pay, remain intact when an employee is utilizing FMLA. **Doctor's certification required within 15 days of first day's absence.**

****You must have been employed for at least one year AND worked at least 1250 hours in that previous year to be FMLA eligible**

_____ This request is for Intermitent Leave under FMLA

FMLA qualifying event: _____

Anticipated Beginning Date: _____ Anticipated Ending Date: _____

_____ **Parental /Adoptive Leave**- An unpaid leave that can be used by an employee for family care. The leave requires Board approval prior to use and it **CAN** be used in conjunction with Childbirth/Recovery Leave. When applicable sick leave and FMLA leave are exhausted, an employee can continue health insurance at personal cost during a parental leave. **Total leave allowance is one year.**

Anticipated Beginning Date: _____ Anticipated Ending Date: _____

_____ **Extended Leave for Personal Reasons**- An unpaid leave available to a maximum of six employees per year not to exceed one year. Must be approved by the Superintendent and the Board. All benefits are suspended during an extended leave. An employee can continue health insurance at personal cost during an extended leave. Employee must notify Superintendent's office of intent to return prior to March 1 of the previous school year.

Reason for leave: _____

Anticipated Beginning Date: _____ Anticipated Ending Date: _____

_____ **I wish to continue with my employee insurance benefit plan at *my own expense* if I should exhaust my sick leave and FMLA. I will make arrangements with the Benefits Coordinator for payment.**

_____ _____

Employee Signature **Date** **Director of Human Resources** **Date**

*****For office use only**

Date Received: _____ **Board Approval Date:** _____ **Actual Return Date:** _____

Date of baby's birth: _____ **Six weeks from date of birth:** _____

Paid Leave Date: _____ **Total number of days:** _____

Unpaid Leave Dates: _____ **Total number of days:** _____

FMLA Dates: _____ **Total number of days:** _____

******Is employee FMLA eligible Yes NO**