Family Partnership Charter School

CERTIFICATED/CLASSIFIED LEAVE FORM (PLEASE REFER TO YOU STAFF HANDBOOK AND OR CBA IF YOU HAVE ANY QUESTIONS)

This form is to be used to request or report an absence. The reasons listed below represent the categories in which an absence may be requested. If your absence request is denied, you may schedule a meeting with the Executive Director to discuss the decision to deny your request. This form will be placed in the personnel leave log, and the absences will be deducted, as appropriate, from the days allotted for absences. (Note: **full-time certificated employees** receive 10 days of leave per year; **part time certificated employees** shall receive proportional sick leave; **full-time classified employees** receive 12 days of sick leave per year.

Employee Information

Employee Name: ____ Today's Date: ______________________________

☐ Certificated ☐ Classified Position: ______________________________

Type of Leave Requested

☐ **Sick Leave (personal Illness or injury)**

☐ **Time Off to Serve as Election Official/Voting/Court/Jury/Witness/Civil Service Duty Leave**

☐ **Family/Medical Leave* (Attach separate FMLA Request Form)**

☐ **Unpaid Leave (state reason):**

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☐ **Industrial Injury Leave (Workers Comp)**

☐ **Personal Necessity (state reason if more than 3 days):**

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☐ **Military Leave**

☐ **CBA personal Day (1 day per year) Certificated Staff Only**

☐ **Other (specify):**

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☐ **Bereavement Leave:** Three days with pay (or five days if one-way travel of more than 250 miles is required) not charged to Personal Leave

☐ **Pregnancy Disability Leave**

☐ **Flex Day:** Flex Days must be preapproved. Please indicate Flex Day. Flex days will not be charged to personal leave. Date:______________________

☐ **Personal Professional Development (specify):** (Outside of school sponsored PD) Each employee shall be eligible without loss of pay or benefits for two (2) professional development leave days per year with **prior administration approval.**

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***For all leaves related to illness or injury (except for sick leave of less than 3 days), please attach a Certification of Health Care Providers noted below.**

Duration of Requested Leave

Leave starts on: ______________________ Expected Return Date: ______________________ Total Work Days: ______________

Is this an extension of an existing leave: ☐ Yes ☐ No

If yes, indicate your original leave dates: from: ______________________ to: ______________________

All requests need to be submitted, other than sick leave or emergencies, at least two (2) weeks prior to the first day you will be off, or as noted in the applicable collective bargaining agreement.

Certification of Health Care Provider

☐ Certification of Health Care Provider is submitted and attached to this form.

☐ Certification of Health Care Provider is not attached but will be mailed separately within 15 days.

Employee Certification

I understand I am responsible for the cost of my insurance benefits (outside of FMLA/CFRA coverage) and it is my obligation to contact the School to make arrangements for premium coverage, where applicable.

I certify my absence during my hours of assigned duty is because of the listed reason in accordance with the applicable collective bargaining agreement, and that all of the information I provided on this form is true and correct.

Employee's Signature: ______________________________ Date: ______________________________

Administration Approval

☐ Approved ☐ Declined (reason): ______________________________

☐ Request for further information (describe): ______________________________

______________________________ ______________________________ ______________________________

Executive Director/Designee Signature Date *Employee's Signature Date* *Coordinator's Acknowledgement Date*

Updated 8/3/17