Delaware Valley School District Unpaid Leave Request Form

To be Completed by Employee and Submitted to District Office for Approval

if you have any questions regarding eligibility, please contact Tammy Phipps at 570-409-2014 or tphipps@dvsd.org

Employee Name: ____

Employee Home Address: ____

Home Phone Number: _____________________________ Cell Phone Number: ___________________________

Building: _________________________________ Position: ____________________________________

Leave Request Type:

____ **Employee Request for Family Medical Leave (FMLA)** Must meet Federal Regulations (Maximum 60 work days)
(Appropriate FMLA *Certificate of Health Condition* form must be completed by your physician and returned within 15 days)

____ **Unpaid Child Rearing Leave** (not to exceed one year from date of birth of child - see contract language)
(You may use up to the following sick days for the recovery of your own body: 6 weeks for vaginal delivery / 8 weeks for a C-section or save your days and take only unpaid leave. **Total time off will be limited to 365 days from birth date of your child.**)

____ **Professional Staff Documented Medical Sabbatical Leave**
(Must provide a statement from your medical doctor attesting to the need)

____ **Support Staff Unpaid Educational Leave per contract language**
(documentation supporting need must be included)

____ **Support Staff Unpaid Medical Leave per contract language if ineligible for FMLA**
(Appropriate FMLA *Certificate of Health Condition* form must be completed by your physician and returned within 15 days)

Reason for Leave (Check all applicable):

___ Birth/Adoption/Pre-Adoption Foster Care *(requires Documentation)*

___ Foster Placement *(requires Documentation)*

___ Employee's Own Serious Health Condition *(requires Medical Certification)*

___ To Care for Family Member or Military Service member with Serious Health Condition* (*requires Medical Certification*)

* When Family Medical Leave is needed to care for a family member or service member, your physician must state the care you will provide and an estimate of the time period during which this care will be provided, including a schedule of intermittent leave or leave on a reduced work schedule, if requested.

___ For a Qualifying Exigency due to the military active duty status or call to active duty status of a spouse, son, daughter or parent *(requires Documentation)*

Anticipated Begin Date of Leave: ____________________ **Anticipated End Date of Leave:** ____________________

Briefly Explain Reason for Leave (if leave is to care for someone other than yourself, please indicate the name of and relationship to the person who needs care.)

Except in the situation of Child Rearing leave, you must exhaust your own available days prior to requesting an unpaid leave. You may however, hold up to 20 sick/personal days for future use plus any of your vacation days when requesting FMLA leave: Please indicate how many days you would like to hold in your balance of days below. If you do not list a number of days to hold it will be assumed that you will be utilizing all sick/personal/vacation concurrently with your FMLA leave and receive payment for your days prior to beginning an unpaid leave for the remainder of the time you will be absent from work.

Please hold the following days for future use following my return to work:

____ Vacation (___ days) ____ Personal (___ days) ____ Sick (___ days)

I authorize the appointing authority to obtain any necessary information regarding my request for Family Medical Leave and to share my leave request with the appropriate parties within the District in order to cover my absence.

Employee Signature: ____ Date: ______________________________