Butte Falls School District #91 February 2005

EMPLOYEE LEAVE REQUEST

Please complete this form within 2 working days of using any paid or unpaid leave.

EMPLOYEE NAME _____

DATE(S) OF ABSENCE	# OF DAYS (HALF or FULL)	TYPE OF LEAVE	NAME OF SUBSTITUTE
_____	_____	**SICK LEAVE**	_____
_____	_____	**PERSONAL LEAVE** (24 Hours Advance Notice)	_____
_____	_____	**FAMILY ILLNESS** Family Member (required): _____	_____
_____	_____	**BEREAVEMENT** Family Member (required): _____	_____
_____	_____	**STAFF DEVELOPMENT**	_____
_____	_____	**SCHOOL BUSINESS/ACTIVITIES**	_____
_____	_____	**VACATION (PAID)**	_____
_____	_____	**LEAVE WITHOUT PAY**	_____

PLEASE COMPLETE THIS SECTION IF APPLICABLE TO YOUR ABSENCE.
Please check one of the following:

- ☐ Your serious health condition (certification may be required) (OFLA/FMLA)
- ☐ Family members with serious health condition (certification may be required) (OFLA/FMLA)
- ☐ Child requiring home care (OFLA)
- ☐ Pregnancy (includes prenatal care, childbirth, and recovery) (OFLA/FMLA)
- ☐ Care for a newborn child (OFLA/FMLA)
- ☐ Placement/adoption of child or adult dependent (OFLA/FMLA)
- ☐ Parent-in-law with condition that poses imminent danger of death, is terminal or requires constant care (OFLA)

NOTE: In some instances it may be necessary for your employer to ask for additional information to determine whether the leave is OFLA/FMLA qualifying.

EMPLOYEE SIGNATURE _____ **DATE** _____

Confidentiality: Any disclosure of medical information will be kept in a confidential file and will be used only to determine eligibility for OFLA/FMLA and to track leave.

☐ Approved ☐ Not Approved Supervisor's Signature _____ Date _____

ORIGINAL - DISTRICT OFFICE 2ND - SCHOOL OFFICE 3RD - EMPLOYEE