FALLBROOK UNION
ELEMENTARY SCHOOL DISTRICT

Leave of Absence and FMLA Request Form

Employee Name:______________________________________ Date:______________

Position: ______________________________________ School/Dept:______________

Employee ID #:______________

TO: Assistant Superintendent of Human Resources

❑ I am requesting Family and Medical Leave pursuant to Article 4.13 (FETA) or Article 13.13 (CSEA) for the following reason:

❑ The birth of a child, or placement of child with me for adoption or foster care
My own serious health condition
Because I am needed to care for my spouse; child; parent due to his/her serious health condition
Because of a qualifying exigency arising out of the fact that my spouse; son or daughter; parent is on covered active duty or call to covered active duty status with the Armed Forces
Because I am the spouse; son or daughter; parent; next of kin of a covered service member with a serious injury or illness

❑ I hereby request an unpaid leave of absence pursuant to Article 4 (FETA) or Article 13 (CSEA) for the following reason(s):

❑General ❑Legislative (Certificated only) ❑Military ❑Sabbatical (Certificated only)

Beginning Date of Leave:	Ending Date of Leave:

Please explain the reason(s) for your leave request below and attach supporting documentation if needed.

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CLASSIFIED EMPLOYEES: By checking this box, I authorize the FUESD Payroll Department to use any available vacation time once I've exhausted my sick leave balance in order to remain in full paid status.

I understand that I must inform the Governing Board of my intentions to return to work for the following school year by April 15 as indicated in Article 4.15.3 (FETA). I will submit a letter to Human Resources.
I understand that my unpaid leave of absence will run concurrently with Family and Medical Leave. Pursuant to FMLA/CFRA, I am entitled to request up to twelve (12) work weeks of Family and Medical Leave in a 12 month period. I understand that the District may use any accrued paid leave such as sick leave, vacation days (Classified Employees ONLY)or any other paid leave which I have accumulated for any part of the twelve (12) work week period that I am covered by Family and Medical Leave Act.

Employee Signature:______________________________________ Date:______________

Recommend Approval❑
Request Denied❑ ______________________________________ ______________
Assistant Superintendent of Human Resources Date