MAURY COUNTY PUBLIC SCHOOLS
REQUEST FOR LEAVE OF ABSENCE

Classified Personnel

(Short-Term & Long Term)

TO: **Maury County Board of Education**

FROM: ______________________________ Phone#: ______________
(Employee Name)

DATE: ______________________________
(Date of Request)

I hereby request a leave of absence from my duties as ______________________________
(Position)

at ______________________________ School for a period of time beginning

______________________________ through ______________________________
Mo. Day Year Mo. Day Year

RETURN DATE:______________ **#Days W/Pay**_____ **#Days W/O Pay**_____

PURPOSE OF LEAVE: (Please check ONE) ***May require a physician's statement**

1. Military/Legislative Service __________
* 2. Maternity __________ Anticipated Period of Actual Disability ______________
* 3. Family and Medical Leave Act Covered Leaves ______________________________
(Explanation)
4. Extended Sick Leave ______________________________
5. Other (please Specify) ______________________________
(If other explanation is required, please attach separate sheets.)

IF ACCUMULATED LEAVE DAYS ARE TO BE USED, PLEASE MARK CORRECT BLANK BELOW.

# of Sick Days to be Used ________ # of Personal Days to be Used ________

Request for leave must be submitted at least thirty (30) days prior to beginning date of leave unless under extreme emergency.

It is my intent to return to the position from which leave is being requested. I shall notify the Superintendent of Schools in writing at lease thirty (30) days to the date of return if I do not intend to return to this position. I understand failure to render such notice may be considered breach of contract.

Signature ______________________________ Date ______________
(Employee)

Address ______________________________
Street City State Zip

- -

Principal Comments: ______________________________

Principal Signature ______________________________ Recommend Leave _______
Do Not Recommend Leave _______

Superintendent of School's or Designee Signature: ______________________________ Date ______________

Leave Approved _______ Leave Denied _______

Date:________________

I, ________________________________, understand that I am requesting

a _______________________ Leave of Absence. This leave will be without pay
(re: medical or personal)

unless I have sufficient unused sick or personal days.

____
Employee Signature

____
Date

MAURY COUNTY PUBLIC SCHOOLS

DOCTOR'S STATEMENT

1. PATIENT'S NAME:____
2. DATE(S) OF DISABLING INURY/ILLNESS:_________________________THRU_________________________
3. DATE ABLE TO RETURN TO WORK:____
4. REASON FOR ABSENCE:

   (PLEASE EXPLAIN INJURY/ILLNESS OR SURGERY – TYPE, KIND, DIAGNOSIS, ETC.)

   ____

   ____

   ____

   ____

   ____

   ____

5. IF SURGERY, WAS IT ELECTIVE? _____YES _____NO
6. COULD THIS CONDITION REOCCUR IN THE NEXT MONTH? (EXCLUDING ACCIDENTS) _____YES _____NO

   IF YES, PLEASE EXPLAIN.____

   ____

   ____

   ____

7. ADDITIONAL INFORMATION

   (PLEASE GIVE ANY ADDITIONAL INFORMATION AS NEEDED.)

   ____

   ____

   ____

   ____

   ____

   ____

8. MEDICAL EXAMINER'S SIGNATURE:_______________________________________DATE:______________

   PRINT OR TYPE THE NAME OF THE MEDICAL EXAMINER:____________________________________

   ADDRESS:____

   PHONE:_____________________ MEDICAL EXAMINER'S SPECIALTY:___________________________

MAURY COUNTY PUBLIC SCHOOLS

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Family and Medical Leave Act of 1993)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

1. Employee's Name:____

2. Patient's Name (if other than employee):______________________________

3. Diagnosis:____

____

____

4. Date condition commenced:__________________ 5. Probable duration of condition:______________

6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services, include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule or hours or days per week.):

   a. By the Physician or Practitioner:______________________________________

   b. By another provider of health services, if referred by Physician or Practitioner:______________________

   ____

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, SKIP ITEMS 7, 8, AND 9 AND PROCEED TO ITEMS 10-14.

Check Yes or No in the boxes below, as appropriate.

	Yes	No	
7.	______	______	Is patient hospitalization of the employee required?
8.	______	______	Is employee able to perform work of any kind? (If No, skip item 9).
9.	______	______	Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employee of essential functions of employee's position, or, if none provided, after discussing with employee.)

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER, COMPLETE ITEMS 10 THRU 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER AND PROCEED TO ITEM 15.

10.	______	______	Is inpatient hospitalization of the family member (patient) required?
11.	______	______	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
12.	______	______	After review of the employee's signed statement (See item 14 below), is the employee's presence necessary or would it be beneficial for the care of the patient?

13. Estimate the period of time care is needed or the employee's presence would be beneficial:____________________

____

ITEM 14 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE.

14. When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

    Employee Signature:____________________________________ Date:____________________

15. Name of Physician (Type or print):____

16. Signature of Physician:____

17. Address of Physician:____

18. Phone Number of Physician:____

19. Date:____

20. Type of Practice (Field of Specialization, if any):______________________________