

MAURY COUNTY PUBLIC SCHOOLS
REQUEST FOR LEAVE OF ABSENCE

Licensed 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: _____ # of Days W/Pay _____ # of 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 Vacation Days to be Used _____ # 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 Director of Schools in writing at least 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 INJURY/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...
a. By the Physician or Practitioner:
b. By another provider of health services...

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.

- 7. Yes No Is patient hospitalization of the employee required?
8. Yes No Is employee able to perform work of any kind? (If No, skip item 9).
9. Yes No 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. Yes No Is inpatient hospitalization of the family member (patient) required?
11. Yes No Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
12. Yes No 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): _____