Today's date:________

Employee ID:100_________

Select one:
Original request
Change request
Extension request

BREVARD PUBLIC SCHOOLS
REQUEST FOR LEAVE OF ABSENCE

Forms and supporting documents must be submitted 10-days in advance of leave

Employee Information

It is the employee's responsibility to ensure that the leave department has the current contact information and communicate any changes

Legal Name_____________________________________

School / Dept name _______________________

Home Address___________________________________

Dept # _________

Mailing address (if different) ___________________________

Job Title __________________________

Phone number _______________________________

Hours worked per day _______

Personal email address ___________________________
*required for correspondence

Date of hire ______________

Sick days balance ______ Sick time start _______ Sick time end _______ Unpaid start date _______
I understand my vacation time will be used once my sick time is exhausted

Leave Type

	Select one	Begin date	End date	Document required*			Select one	Begin date	End date	Document required*
	FMLA - Employee			FMLA certification			Personal - FMLA reasons			Physician statement with begin and end dates
	FMLA - Family member			FMLA certification			Personal - Public service			Explanation required below
	FMLA - Birth of a child			FMLA certification			Personal - Jury duty			Summons or verification from clerk of court
	FMLA - Parental leave *must be taken within 30 days of delivery or adoption			Written statement from licensed physician verifying pregnancy and estimated birth date			Personal - Union			
	FMLA - Adoption			Adoption or court papers			Personal - Charter School			Verification from Charter school
	FMLA - Military			Military order			Personal - Professional leave			Registration deadline from institution
	Injury in the line of duty *Will be charged to FMLA if applicable			First report of injury filed with risk management			Personal - Educational leave			Course schedule upon application
	Extended medical			Physician statement with begin and end dates			Personal - Child rearing *not to exceed balance of school year + 1 year			Proof of birth
							Personal - Other *Explanation required			Explanation required below.

*For detailed information on required documents please refer to the leave guidebook

Personal leave explanation: ____
____

I understand that my insurance benefits will continue during my leave of absence, and I will be responsible to directly pay for those benefits during any unpaid portion of the leave. I may make changes to or cancel my benefits by submitting a Benefit Change form to the Employee benefits office within 30 days of the first day of my unpaid leave.

I understand that I am required to present a physician's note upon my return from a medical leave over 5 days.

I understand that it is my responsibility to communicate changes to my leave of absence as soon as possible to my coordinator and supervisor.

I understand that if I do not return upon the completion of my leave and have not requested additional leave, I am considered absent without leave.

Check this box only if you are married to an actively-at-work, benefits eligible BPS employee

Signature of Employee: ______________________________ Date:

Principal / Admin / Supervisor Acknowledgment: ____________________________ Date: Recommend Not Recommend

Leave Department Representative: ______________________________ Date: Approved Not Approved