File: GCBEA-A

Application for Leave without Pay
(Reference File GCBEA – Copy attached)

NAME:_____ SCHOOL:_____DATE:_____

SECTION I:

1. I wish to make application for Leave without Pay for the period

FROM:_____, 200___
(month/day)

TO:_____, 200___
(month/day)

If intermittent leave is requested, please include a letter documenting the reason intermittent leave is needed. Also include a completed Certification of Physician or Practitioner with your application if reason for request is due to personal or family illness (form attached).

2. Reason for Leave without Pay: (check one)

_____ The birth and first year care of a child

Date of birth:_____ (date/month/year)

_____ The adoption or foster placement of a child

Date of placement:_____ (date/month/year)

_____ The serious health condition of an employee's spouse, parent, or child

_____ The employee's own serious health conditions (accrued sick leave must be used before unpaid leave commences)

Signature of Employee_____

Section II:

The above application for Leave without Pay is:

APPROVED_____ UNAPPROVED_____

Signature of Superintendent or Designee_____
Date_____

THE EMPLOYEE SHALL COMPLETE SECTION I AND SUBMIT THE FORM TO THE PERSONNEL OFFICE FOR PROCESSING. THE FORM SHOULD BE SUBMITTED 30 DAYS IN ADVANCEOF THE DATE LEAVE IS TO BEGIN EXCEPT IN AN EMERGENCY SITUATION.

PATRICK COUNTY PUBLIC SCHOOLS

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
***(For use with LEAVE without Pay application*)**

1. Employee's Name_____
2. Patient's Name (if other than employee) _____
3. Diagnosis:_____
   _____

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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 of hours per day or days per week:)

   a. By a Physician or Practitioner:

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

CHECK *YES* OR *NO* IN THE BOXES BELOW, AS APPROPRIATE:

	YES	NO	
7.	☐	☐	Is inpatient hospitalization of the family member (patient) required?
8.	☐	☐	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?
9.	☐	☐	After review of employee's signed statement below, is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)

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

11. When 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.

12. _____ _____
    Employee's Signature Date

13. _____ _____
    Signature of Physician or Practitioner Date

14. _____
    Type of Practice (Field or Specialization, if any)