ST. VRAIN VALLEY SCHOOLS
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Please return form to:
Department of Human Resources, Leave of Absence
395 S. Pratt Pkwy, Longmont, CO 80501
Fowler_Joe@svvsd.org
Phone: 303-682-7282 Fax: 303-682-7399

REQUEST FOR LEAVE OF ABSENCE (continuous or intermittent)

Si desea este documento en español, envíe un correo electrónico a Fowler_Joe@svvsd.org

TO BE COMPLETED BY EMPLOYEE

Name		**SVVSD ID #**	**SSN #** **XXX-XX-**_____
Full Address		**Home Phone**	**Cell Phone**
		Email Address	
		Preferred Contact Method ☐ Work E-Mail ☐ Personal E-Mail ☐ Home Phone ☐ Cell Phone	
Position/Title		**Location/Department**	
Supervisor		**Employee Type** ☐ Classified ☐ Professional/Technical ☐ Licensed ☐ Administrator	
Anticipated Last Day at Work:	**Anticipated Return to Work Date:**	☐ Check if requesting leave for intermittent use. **Starting Date:**	**List any leave planned for two (2) weeks prior to the first day of LOA:**

☐ My spouse is currently employed by SVVSD. Their name is:

Note: Per SVVSD policy in accordance with section 825.302(e) of the Family and Medical Leave Act (Scheduling planned medical treatment) "When planning medical treatment, the employee must consult with the employer and make a reasonable effort to schedule the treatment so as not to disrupt unduly the employer's operations, subject to the approval of the health care provider. Employees are ordinarily expected to consult with their employers prior to the scheduling of treatment in order to work out a treatment schedule which best suits the needs of both the employer and the employee."

TYPE OF LEAVE

(note: All LOA requests will be considered for FMLA protection. Employees will be notified of FMLA eligibility and/or designation)

I request a leave of absence for the purpose of:

- ☐ **Parental**
  - ☐ The birth of a child, or the placement of a child with you for adoption or foster care
    Expected date of delivery or date of adoption/placement: _____
- ☐ **Medical**
  - ☐ A serious health condition that makes you unable to perform the essential functions of your job
- ☐ **Caregiver**
  - ☐ A serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, or
  - ☐ Other relationship: _____ for whom you are needed to provide care
  - ☐ Active Duty Because of Any Qualifying Exigency
  - ☐ Service Member Caregiver Leave
- ☐ **Military** *(Attach official orders.)*
- ☐ **Other/Personal** *(Must have both Supervisor AND HR approval.)*
- ☐ **Certified Personnel Only - Extended Leave** *(Attach letter indicating duration, purpose, and substantiating reasons for extended leave. Include evidence of support (medical certification, college registration, teaching abroad offer letter, etc.))*
  ☐ Professional/Educational (Article 25.1/25.2) ☐ Medical (Article 25.3) ☐ Personal (Article 25.4)

REQUEST FOR PAY DURING LEAVE OF ABSENCE

An unpaid Leave of Absence is only approved when receiving compensation from an outside source, or after having exhausted all available paid leave.

I am requesting to be paid by the means checked below (The LOA Coordinator will verify eligibility for compensation requested):

☐ Classified and Professional Technical Employee Paid Leave (PTO, accrued Sick Leave, Vacation)
☐ Licensed Employee Paid Leave (Annual Leave, accrued Sick Leave per Article 21.3 and 21.4)
☐ Administrator Sick Leave
☐ Short Term Disability + Paid Leave (if elected and approved for Short Term Disability by The Hartford)
☐ Short Term Disability only, after using paid leave during the 14-day waiting period (if elected and approved for Short Term Disability by The Hartford
☐ Individual FAMLI account (if enrolled with the State of Colorado)
☐ PERA Short Term Disability (60 day waiting period)
☐ Other Outside Source pay (ex. Short- or Long-Term Disability policy other than The Hartford or PERA, legal pursuit of compensation, etc.)

Please be aware that you may have other leave benefits available to you to ensure you are paid during your approved Leave of Absence (ex. Sick Leave Bank, Diff Dock). Sick Leave Bank Request forms will be provided if you meet the criteria for applying per the SVVEA Agreement or applicable Employees' Handbooks. Diff Dock will be automatically applied for Licensed employees when eligible in accordance with Article 21.5.

Prior to commencing Leave:

☐ I understand the procedures and policies as identified by the SVVEA Agreement, Employees' Handbook, and/or FMLA policy and that my accrued, unused paid leave will be used unless otherwise agreed upon.
☐ I understand that if I do not return to work as agreed or fail to provide documentation for a possible extension, my employment may be terminated.
☐ If applicable, I elect to continue my insurance coverage during my leave, and I will pay any premiums due that have not been paid. If eligible, SVVSD will continue its contribution toward insurance benefits for which I am enrolled for up to 12 weeks while on approved LOA, but I am responsible for the full premiums following that time for any unpaid leave.

For Parental Leave Only:
☐ If I wish to add insurance coverage for a newborn child or change my Flexible Spending Account(s), I understand that I must complete a benefit election within 30 days of my child's birth.

Employee Signature: _____ **Date:** _____

ACKNOWLEDGEMENT SIGNATURE

Supervisor/Principal or HR Representative: _____ **Date:** _____