ST. VRAIN VALLEY SCHOOLS
academic excellence by design

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

REQUEST FOR LEAVE OF ABSENCE (continuous or intermittent)

TO BE COMPLETED BY EMPLOYEE

Name		**SVVSD ID #**	**SSN #** **XXX-XX-**_____
Full Address		**Home Phone**	**Cell Phone**
		Email Address	
Position/Title		**Location/Department**	
Supervisor		**Employee Type** ☐ Classified ☐ Professional/Technical ☐ Licensed ☐ Administrator	
Last Day at Work	**Return to Work Date**	**List any leave planned for two (2) weeks prior to the first day of LOA:**	

☐ My spouse is currently employed by SVVSD. His/Her 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, for which 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)

Prior to commencing a leave, I understand the procedures and policies as identified by the Master Agreement, Employees' Handbook, and/or FMLA policy and that my accrued, unused paid leaves 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 FMLA, but I am responsible for the full premiums following that time for any unpaid leave. 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: _____