LEAVE OF ABSENCE REQUEST FORM[1]

Prior to the start of your leave, please complete and return this form along with the supporting documentation to:
Coatesville Area School District, Attn: Human Resources Department, 3030 C.G. Zinn Road, Thorndale PA 19320, 610-672-9962 (fax)

Employee Name: _____ **Date of Request:** _____

Employee Title: _____ **Work Location:** _____

Supervisor Name: _____

Why are you seeking a leave of absence?[2] _____

What kind of leave are you seeking?[3] _____

Dates of requested leave of absence: _____ Anticipated return to work date: _____

When do you desire your leave to begin? _____

Medical Leave

Do you have a serious health condition which makes you unable to perform the duties of your job?	☐ Yes	☐ No
Are you seeking a leave of absence as a result of a work-related disability or illness?	☐ Yes	☐ No

Parental Leave

Are you seeking leave for the birth of a son or a daughter or to care for a newborn child?	☐ Yes	☐ No
Are you seeking leave due to placement of a son or a daughter for adoption or foster care?	☐ Yes	☐ No

Other Leave

Will you be caring for a spouse, son, daughter, or parent who has a serious health condition?[5]	☐ Yes	☐ No
Are you seeking leave for to an exigency due to the fact that your spouse, child or parent is on active duty?	☐ Yes	☐ No
Are you seeking leave to care for an active covered service member?[4]	☐ Yes	☐ No
Sabbatical-Restoration of Health?	☐ Yes	☐ No
Sabbatical-Professional Development?	☐ Yes	☐ No

I certify that the above information is accurate. I understand that I must provide the supporting documentation requested by the School District as required by applicable law, contract and/or policy in order for my leave of absence to be considered. In addition to completing this form, I will notify my supervisor of my absence.

I acknowledge that I have reviewed the applicable leave policy and/or my Collective Bargaining Agreement or Administrative Agreement and that I will comply with the specifics within the policy. Per the FMLA policy, I understand that if I meet the qualifying criteria, then the District will designate my leave as FMLA.

I understand that if I am unable to return to work on the date approved, then I must request an additional leave prior to the anticipated return to work date and provide supporting documentation or I may be subject to termination of employment.

For Sabbatical Leaves - I understand that this application is made in conformance with the provisions for sabbatical leave as outlined in the Pennsylvania Public School Code and School Board Policy and Regulations. I signify by my signature that I agree to return to my employment with the Coatesville Area School District for a full school term immediately following this sabbatical leave.

Employee Signature: _____ Date: _____

In order to ensure you are eligible for a leave of absence under law, applicable collective bargaining agreement, applicable administrator compensation plan, or school district policy or practice, you are required to complete this form. Failure to provide any required information may result in denial of your leave request or other important benefits.

The Coatesville Area School District does not discriminate in employment, educational programs, or activities based on race, sex, handicap, or national origin. This policy of non-discrimination extends to all other legally protected classifications in accordance with state and federal laws including Title IX of the Education Amendments of 1972 and Section 503 and 504 of the Rehabilitation Act of 1973.

[1]Although this form is intended to be used as the initial intake form for a request for a leave of absence, other forms may be necessary to be completed and other information may be required in order for you to be qualified for any particular type of leave of absence. Nothing in this form is intended to dispense with your need to complete and/or provide required information, documentation or forms.

[2]If you need additional space, please use and refer to an additional sheet(s) of paper.

[3]The School District reserves the right to designate the leave as it determines proper and your request for a particular type of leave is not determinative.

[4]The term "covered service member" means a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. 29 U.S.C.A. § 2611 (16).

[5]A "serious health condition" is defined in the FMLA as "an illness, injury, impairment or physical or mental condition that involves:

(1) inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility… or any subsequent treatment in connection with such inpatient care; or

(2) continuing treatment by a health care provider. A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

(i) A period of incapacity (i.e., inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom) of more than three consecutive calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves: (A) treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or (B) treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

(ii) Any period of incapacity due to pregnancy, or for prenatal care.

(iii) Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which: (A) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider; (B) continues over an extended period of time (including recurring episodes of a single underlying condition); and (C) may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

(iv) A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. * * * Examples include Alzheimer's, a severe stroke, or terminal stages of a disease.

(v) Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services… for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation), severe arthritis (physical therapy), kidney disease (dialysis). See 29 CFR §825.114.