Elizabethton City Schools

LEAVE OF ABSENCE REQUEST

Date _____ Phone _____

Name _____ Social Security No. _____

Home Address _____
Number Street City State Zip

School/Department _____ Position _____ Grade _____

I hereby request a leave of absence from my duties as follows:

Beginning Date _____ Ending Date _____

For the following reason:

☐ medical ☐ educational ☐ maternity ☐ child care ☐ legislative service ☐ military ☐ other _____

Last day scheduled to work before leave commences will be _____

☐ *Check here if you wish to use <u>all</u> available, applicable **paid** leave before taking an **unpaid** leave of absence.*

OR

Check applicable boxes and complete necessary information below if you wish to use only <u>selected</u> paid leave:

☐ Wish to use sick leave _____ # of days ☐ Wish to use vacation days _____ # of days

☐ Wish to use personal days _____ # of days ☐ Intend to apply for Sick Bank (Member only)

☐ Compensatory days _____ # of days (Paraprofessional only)

(Sick leave is available only if a medical condition exists for employee or family member. Sick leave for maternity purposes is available during the period of the physical disability only, as determined by a physician. You may also use sick leave for up to a period of thirty (30) days for adoption purposes. A copy of supporting documentation from the adoption agency must be provided.) *TCA 49-5-710, Sick Leave 5.302*

I understand that I forfeit my rights if I fail to proceed according to this request. I shall notify the Director of Schools in writing at least thirty (30) days prior to the date of return if I do not intend to return to this position. I understand failure to render such notice may be considered breach of contract.

_____ _____
Employee Signature Recommended Approval of Supervisor/Principal

**********Please complete insurance information on back for leave without pay only.**********

— FOR OFFICE USE ONLY—

Employment Date _____ 1250 Hours _____ ☐ FMLA

Name of replacement _____ ☐ To be announced ☐ No replacement

Number of leave days available: sick _____ personal _____ vacation _____ comp _____

Approved for the period beginning _____ and ending _____.

Signed _____ Date _____
Director of Schools

Revised 8/21/2006 - Blue

LEAVE WITHOUT PAY

Insurance Information: You must check one or more if you have insurance and are taking a leave without pay.

☐ Cancel insurance after last deduction is credited from payroll check: ☐ Health ☐ Dental

☐ Family Medical Leave Without Pay (Is not available for educational leave, legislative service or military leave)

- Maximum period of twelve weeks per school calendar. Approval is granted through the Central Office. Employee continues to pay his/her portion of the health/dental insurance premium for three months. When your family medical leave is exhausted, you must (1) return to work, (2) be coded as leave without pay (Code 21) if you continue your insurance, employee pays 100% of premium, or (3) be coded as leave without pay (Code 22) insurance canceled with the option to reactivate within 31 days upon your return.

☐ Leave Without Pay (Insurance Canceled – Code 22) Cancel my ☐ health ☐ dental insurance after FMLA

- Maximum period of two years. You must submit a Request for Cancellation while on active pay status. When you return to active employment, you have 31 days to reactivate your coverage by completing an Add/Change Enrollment Form. **If you fail to enroll within 31 days, you will only be eligible by satisfying one of the special enrollment provisions. If you return to work after a six-month leave period, you will be subject to the Plan's six-month preexisting condition requirement.**

☐ Leave Without Pay (Insurance Continued – Code 21) Continue my ☐ health ☐ dental insurance after FMLA

- Maximum period of two years. You will be responsible for 100% of the health premium and will be billed at home each month. You may continue insurance coverage while on an approved leave of absence and then request cancellation if unable to continue paying the premium (see Code 22) for details. Partial years of service, leaves of absence (without pay), or part-time service can affect advancement on the salary scale.

If you have any questions regarding the above options, please call the insurance administrator at 547-8009.

Signed _____
Employee Requesting Leave Without Pay