Cobre Consolidated Schools **Request for Leave Form**

Submit leave form to your immediate supervisor no later than 5 working days prior to proposed date(s) in accordance with the Personnel Policy and Labor Agreements. Failure to do so may mean that your leave may not be approved. In the event of an unplanned absence, complete the Request for Leave Form as soon as possible.

Name of Employee: _____ Date Submitted: _____

Total Days Absent From Work:_____ Will a substitute be required: ___ Yes ___ No

School/Department: _____ Supervisor: _____

TYPE OF ABSENCE REQUESTED:

___ Annual Dates requested: _____

___Personal Circle: 1st 2nd 3rd Date(s) requested: _____

___Sick Leave Dates requested: _____

___ Bereavement _____ Date(s) requested: _____
(State relationship; refer to Personnel Handbook and Labor Agreements)

___ Jury Duty Summons attached: yes no Date(s) requested:_____

___ Leave without Pay Date(s) requested: _____

___Extended Sick Leave Date(s) requested: _____

FAMILY AND MEDICAL LEAVE (FMLA)
If annual leave, sick leave, personal leave or leave without pay will be used under the Family and Medical Leave Act of 1993, please provide the following information:

___ **I herby invoke my entitlement to Family and Medical Leave for:**

___ Serious health condition of self

___ Serious health condition of spouse, son, daughter or parent

___ Birth/Adoption/Foster Care
(Contact your personnel and/or payroll office to obtain additional information about your entitlements and responsibilities under the Family and Medical Leave Act (FMLA). Medical certification of a serious health condition may be required. FMLA forms will be mailed to the employee and must be returned to the Payroll Office in a timely manner.)

CERTIFICATION: I hereby request leave from duty as indicated above and certify that such leave is requested for the purpose(s) indicated. I understand that I must comply with my school district policies and/or current Labor Agreements when requesting leave (and provide additional documentation, including medical certification, if required) and that falsification on this form may be grounds for disciplinary action.

Employee Signature: _____ Date: _____

PRINCIPAL/SUPERVISOR APPROVAL

___ Approved ___ Disapproved Comments: _____

Principal/Supervisor Signature: _____ Date: _____

SUPERINTENDENT APPROVAL

___ Approved ___ Disapproved Comments: _____

Superintendent Signature: _____ Date: _____