

NEW HANOVER COUNTY SCHOOLS
REQUEST FOR EXTENDED LEAVE OF ABSENCE
(Form should be completed if an employee will be out for more than 10 days.)

Name _____ Last 4 digits of SS No. _____

Home Address _____

Telephone No. _____

School/Department _____ Position _____

Type of Leave Requested (Check one)

- | | |
|--|---|
| * <input type="checkbox"/> Family Leave
(Physician's Statement must be attached.) | <input type="checkbox"/> Educational Leave
(Acceptance documentation must be attached.) |
| * <input type="checkbox"/> Medical Leave
(Physician's Statement must be attached.) | <input type="checkbox"/> Other |

DATE LEAVE SHOULD BEGIN

EXPECTED DATE TO RETURN TO WORK

I am requesting to use the following benefits in accordance with State Board of Education Guidelines:

- | | |
|--|---|
| <input type="checkbox"/> Sick Leave | <input type="checkbox"/> Personal Leave (Teachers Only) |
| <input type="checkbox"/> Annual Leave | <input type="checkbox"/> Extended Sick Leave (Teachers Only) |
| <input type="checkbox"/> Request Voluntary Shared Leave
(Separate VSL application must be completed.) | <input type="checkbox"/> Bonus Leave / <input type="checkbox"/> Comp Time |

NHCS requires that an employee must exhaust all applicable leaves before beginning an unpaid leave of absence.

ALL LICENSED EMPLOYEES AND ASSISTANTS: I understand that if I request a leave of absence for more than 6 consecutive months, the principal has the right to release my position and hire a permanent replacement.

LICENSED EMPLOYEES: I understand that for computing time as a probationary teacher, I must work **not less than** 120 workdays as a full-time permanent employee in a normal school year.

ALL EMPLOYEES: I understand that if I go off payroll, I am responsible for all miscellaneous deductions made through payroll deduction. State reporting procedures require an employee on "12-month installment pay" to be paid the lump sum of earned pay when taking a leave of absence without pay. I understand that upon exhaustion of all approved leaves – both paid and non-paid – (including FMLA), I will return to work or my employment will be terminated. I also understand the requested family or medical leave will be counted against my FMLA entitlement. **IF ON MEDICAL LEAVE, I will provide the Benefits Department with a Fitness for Duty form from my physician prior to my return to work.**

Employee's Signature / Date

Principal's/Supervisor's Signature / Date

* According to the Family and Medical Leave Act (FMLA), an employee is eligible to take up to 12 workweeks of leave because of a serious personal health condition, birth of a child, placement of an adopted or foster child, or to care for a spouse, son, daughter, or parent who has a serious health condition. The only stipulations are the employee must have been employed for at least one year and worked 1250 hours over the previous 12 months. During the 12 workweeks of FMLA Leave, the employer's contribution for health insurance premiums will be paid for full-time employees. The employee is responsible for employee cost. Family and medical leaves may be requested beyond the 12 workweeks.

Completed form with the attached documentation should be submitted to Human Resources – Benefits Department.