Conroe Independent School — Application for Leave

Please print

Based on Policy DEC (Local)

Employee's name ______________________ Position ______________________

Employee ID # ______________________ Date(s) of leave requested ______________________

Campus/Department ______________________ Anticipated return date ______________________

Instructions for completing form. This form, based on local policy DEC, addresses leaves that must be approved by the Department of Human Resources. Upon completion, give the form to your campus principal/supervisor who will sign it and forward the request to the Department of Human Resources.

Type of Leave Requested

☐ **Extended Sick Leave** *(includes maternity)*

Note: To be eligible for extended sick leave, an employee must have been employed by Conroe ISD for the previous 12 months in a full-time capacity.

- ☐ I have been absent at least five consecutive sick days (self). dates ______________________
- ☐ I have been absent at least five consecutive days for a family member who must have my presence. ☐ *spouse* ☐ *child* ☐ *parent* ☐ *other (specify)* ____________ dates ______________________
- ☐ I understand that if I am granted the extended sick leave, that after the extended days are exhausted, I will be docked a full day's pay for each day of absence.

☐ **Temporary Disability Leave** *(full-time educators)*

☐ **Military Leave** *(attach a copy of orders)*

☐ **Assault Leave** *Campus principal/building supervisor must attach statement verifying the physical assault, date, time, and injuries received.*

Date of physical assault ______________________

Time of physical assault ______________________

Injuries received ______________________

- ☐ I understand any assault leave benefits shall be coordinated with temporary income benefits due from workers' compensation so that my total compensation from temporary income benefits and assault leave will equal 100% of my weekly rate of pay.
- ☐ I understand I will not be charged with State sick leave to accommodate physical assault leave.

☐ **Adoption leave**

My spouse ☐ *does* ☐ *does not* work for the district

- ☐ I have attached documentation of the adoption.
- ☐ I understand that once my extended sick leave days are exhausted that I will be docked a full day's pay for each day of absence.
- ☐ I am aware that I cannot use State granted sick leave for well baby care.
- ☐ I am aware that I may be eligible for a concurrent leave of 12 weeks under the Family Medical Leave Act *(note: there is a Family or Medical Leave Request which must be competed by the employee and approved by the Division of Human Resources)*.
- ☐ I understand that I am not eligible to take adoption leave and parenting leave in the same school year.

☐ **Family Medical Act** *See district from #DEC(L)(E)2 for application*

______________________ ______________________

Employee signature *Date*

Administrator Acknowledgement

______________________ ______________________

Principal/ Supervisor *Date forwarded to Division of Human Resources*

Division of Human Resources ☐ approved ☐ not approved

FMLA ☐ yes ☐ no FMLA hours ____________

______________________ ______________________

Signature *Date*

Medical Certification of Illness by Doctor

Conroe Independent School District

To the employee: **Local policy DEC requires a certification of your illness or that of a family member for whom you must provide care. This form is to be completed by a physician who is licensed to practice medicine in the United States.**

I hereby grant permission to my doctor to release personal health information to the Conroe Independent School District for the purposes of this leave of absence request. This completed form must be included at the time the leave application is submitted.

_______________________________ *Signature of Employee* _______________________ *Date*

I certify that _______________________________ is under my care and has a serious health condition that prohibits him/her from performing the functions of the job.

Date he/she is/was first unable to work _______________________________ .

If the absence is for maternity reasons, the estimated date of delivery is _______________________ .

Estimated date that he/she will be able to return to work _______________________________

The following are appropriate medical facts which I am able to give you concerning the illness of this patient

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____

Or If the leave of absence is for a family member,

I certify that _______________________________ is under my care and has a serious health condition that requires the presence of your employee _______________________ to remain with him/her to provide the necessary care.

Relationship to employee ☐ spouse ☐ child ☐ parent ☐ other *(specify)* _______________

The presence of the employee is necessary from *(date)* ____________ through *(date)* ____________ .

The following are appropriate medical facts which I am able to give you concerning the illness of this patient:

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Note: **This form is not appropriate for employees returning from medical leave under the FMLA.** ***See form DEC(L)E)5.***

_______________________________ *Stamped or typed name of physician*

_______________________________ *Signature of physician*

_______________________________ *Date*

_______________________________ *Typed name of licensing board and registration number of practitioner*

DEC(L)(E)3
1/09