Wood County Schools Leave of Absence Request (Leave without Pay)

Refer to WCS Policies 4151, 4152, 4152.2, 4152.3

Directions: Complete all sections of the form. The employee may not accept other employment while on leave. Prior to taking leave, all requests MUST be approved by the Superintendent and Board of Education. If an emergency occurs and this is not possible, notify your supervisor immediately and complete the form as soon as you are medically able.

Section 1 – General Information

Employee Name: _____ Employee ID Number: _____

Address (Street/City): _____ State: ____ Zip Code: _____

Phone Number: _____ Email: _____

Emergency Contact (Name/Phone Number): _____

Present Position: _____School Name/Location: _____

Section 2 – Dates (Leave cannot extend past one year.)

First Date of Leave: _____ Last Date of Leave: _____ Total Number of days requested: _____

Number of Leave of Absence days approved over the past 12 months: _____

Section 3 – Reasons and Accumulation (Supporting Documentation MUST be attached for leave to be approved.)

- ☐ Medical Leave (Unable or unfit to perform duty due to physical or emotional condition.)
- ☐ Military Leave as defined in Policy 4152.2.
- ☐ Critical Illness of person who is dependent upon the employee as defined in Policy 4151.
- ☐ Personal Leave, which requires the advance approval of the Superintendent.
- ☐ Parental Leave as defined in Policy 4152.3.
- ☐ Special educational or governmental assignment.
- ☐ Workers' compensation.

In your own words, explain or describe the circumstances which you believe justify a leave of absence for the reason checked above. _____

_____

FOR WCS ADMINISTRATION USE ONLY

Board of Education Action: Approved ☐ Not Approved ☐ Date: _____

Section 4 – Assurances

☐ I understand that a Leave of Absence cannot extend beyond one year and the Wood County Board of Education may terminate my employment at the end of one calendar year for employees who cannot return to work.

☐ I understand that I am responsible for the employee's portion of insurance premiums while on a leave of absence.

☐ I understand that a leave of absence means an employee plans to return to work and that any notice of resignation, retirement, or disability may cause a termination of employment and loss of insurance benefits.

☐ I understand that for absences that go beyond 30 days, a recertification from a medical provider is required. (Waived for pregnancy, childbirth, infant bonding, worker's compensation and military.)

By typing or signing your name, you affirm that, to the best of your knowledge, the information in this request is correct.

_____ _____

Signature of Employee or Representative Date

_____ _____

Signature of Supervisor Date

Section 5 – Comments and Approval from Human Resources

Approved ☐ Not Approved ☐

Comments: _____

_____ _____

Signature of Assistant Superintendent Date

Section 6 – Finance Department Personal Day Verification

Does the employee have any vacation or personal leave days remaining? Yes ☐ No ☐

_____ _____

Signature of Finance Office Date

Section 7 – Comments and Approval from Superintendent

Approved ☐ Not Approved ☐

Comments: _____

_____ _____

Signature of Superintendent Date