



REQUEST FOR LEAVE

EMPLOYEE INFORMATION

Social Security #: _____ - _____ - _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

School/Department: _____

Position/Title: _____

LEAVE DATES

Date Leave to begin: _____

Date anticipated return to work: _____

A Physician's Statement must accompany all requests for leaves due to a medical condition. The Physician's statement form can be obtained from the Human Resources Department or on the District's website (www.rps205.com). Both the Request for Leave of Absence from and the Physician's Statement must be returned to the Human Resources Department prior to your request being reviewed.

LEAVE REQUESTED

(select one)

Educational *
(require copy of class schedule)

Medical/Disability
(Maternity)

Military
(require copy of orders)

Sabbatical*

Unpaid

** will be submitted to committee for approval*

Family Medical Leave Act

- self
- spouse
- child
- parent
- adoption
- Intermittent

Other
(please explain)

USE OF PERSONAL DAYS: All available Personal Illness & Personal Business days will be used during period of disability.

Employee Signature

Date

Mail to: HUMAN RESOURCES DEPARTMENT, 201 S. Madison St., Rockford, IL 61104 FAX: 966.3148
For information regarding Disability contact: Sara Jones - 966.3098 or jones@rps205.com

Approved / Denied - Human Resources Department

Date