

Pleasantville Public Schools – Family Leave Request

Please fill out all information. Incomplete requests will not be processed and sent back to employee.

****Upon completion forward to the Office of Human Resources. ****

Name: _____ Location/Department: _____

Home Address: _____

Position: _____ Principal/Administrator: _____

Are you tenured in your position? _____ Yes _____ No

Original date of hire in district: _____

Have you worked the qualifying hours in the previous year? _____ Yes _____ No

Dates of requested leave:

Date of LAST work day: _____

START date of leave (without pay): _____

Is LEAVE to be taken under: _____ Family Medical Leave Act (FMLA)

_____ New Jersey Family Leave

Amount of leave requested: _____ weeks (NOT to exceed 12)

_____ Consecutive _____ Intermittent (*) _____ Reduced (*)

Anticipated date of RETURN: _____

***Intermittent or Reduced leave must be approved by your employer.**

Is this your own illness or that of a family member? _____ Self _____ Family Member

Qualified family member (name): _____

Relationship: _____

Please be advised that if you are on leave and you no longer are being paid by the district you will be required to COBRA your medical, prescription, dental and vision insurance coverage. Your insurance coverage with the district will end approximately 45-60 days from your last paid day with the district. At that time, the district will forward you information concerning the COBRA process.

Has your Principal/Supervisor been made aware of your request? _____ Yes _____ No

Employees Signature Date

Principal/Administrator Signature Date

