Pleasantville Public Schools – Family Leave Request

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

****Once form is completed and signed by your department/building administrator, please forward to the Office of Human Resources for the Assistant Superintendent's approval****

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. You 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

_____ _____ _____ Approved _____ Denied

Assistant Superintendent's Signature Date