



## Human Resource Services

# Request for Disability Leave of Absence

## Certificated Employees

Name:	Social Security Number:
Street Address:	City/State/Zip:
Home Phone:	Work Phone:
Position Title:	Hire Date in District (mm/dd/yy):
Date Leave Begins (mm/dd/yy):	Date Leave Ends (mm/dd/yy):
School/Department:	Subject/Grade Level (if applicable):

Reason for Leave: (Please refer to your union contract.)

The request for this leave of absence is made in accordance with the provisions

\_\_\_\_\_ and with the approval of \_\_\_\_\_

My address while on leave will be: \_\_\_\_\_

If the above request is granted, I understand that I will:

1. Contact the Benefits Office regarding benefits and insurance coverage (if any) during my leave of absence.
2. Comply with the requirements and conditions set forth in the union contract for the bargaining unit to which I belong.
3. Request any needed extension of leave in writing.
4. Give written notice no less than thirty (30) days before the expiration date of my leave regarding whether or not I intend to return.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### For Human Resource Services Use Only

Disability allowance verified with STRS by: \_\_\_\_\_

Date: \_\_\_\_\_

Ten consecutive years of service in district immediately prior to leave date: \_\_\_\_\_

Yes

No

Hold Position: \_\_\_\_\_

Transfer to Unassigned: \_\_\_\_\_

Recommendation for leave approved by: \_\_\_\_\_

Date: \_\_\_\_\_

Leave of absence granted in accordance with the above agreement: \_\_\_\_\_

Signature: Director, Human Resource Services \_\_\_\_\_

Date \_\_\_\_\_

Agenda Date: \_\_\_\_\_

T.A.P. No. \_\_\_\_\_

cc: Principal or Supervisor, Employee, Personnel File

*Reference: Education Codes 22126 and 44986*