Human Resources Department
807 Northeast Broadway
Minneapolis, MN 55413-2398
(612) 668-0500

LEAVE OF ABSENCE REQUEST FORM-*NON-LICENSED*

MPLS
MINNEAPOLIS PUBLIC SCHOOLS

Purpose: To be completed by all employees for days away from your work site consisting of 11 consecutive workdays or more. **NOTE: You are responsible for contacting your retirement board to determine how this leave of absence will affect your retirement. The district has no legal obligation to notify PERA, etc. of your leave of absence. Please check with Benefits for questions regarding district benefits.**

Employee Name: _____ Social Security #: _____

Employee Email Address: _____ Employee Home Phone: _____

Site/Location: _____ Job Title: _____ FTE/Hours_____

Initial Request for Leave of Absence: *(Check One)*

- ❑ Personal w/o Pay
- ❑ Student Teaching (**documentation needed**)
- ❑ Public Service (**documentation needed**)
- ❑ Organization (**documentation needed**)
- ❑ Study w/o Pay*
- ❑ Other _____
- ❑ Immediate Family Illness (**FMLA**)
- ❑ Medical (**FMLA**)
- ❑ Child Care/Adoption (**FMLA**)
- ❑ Child Care/Maternity (**FMLA**)
- ❑ Child Care/Paternity (**FMLA**)
- ❑ Military (**Documentation Needed**)

Note: Non-Licensed employees must notify the District by March 15 of the school year preceding the school year in which you are returning from leave.

(*) Letter of acceptance from College/University stating you have been accepted into or continuing in a program.

All leaves that fall under FMLA (Family Medical Leave Act) require written documentation with this form.

If you are approved for a one-year leave of absence, you are waiving your right to return to your previous work location. You will still retain your right to return to a position in the district.
Leaves will not be processed without end date.

"FMLA" (Family Medical Leave Act) indicates active rate for health benefits up to 12 weeks. This form will act as formal FMLA notification. Written medical documentation to take this leave must be attached with this request. Medical clearance (completed return to work authorization form) is required prior to duty if out 11 consecutive work days or more.

I am requesting a leave of absence starting on _____ **My leave will end on**_____
Start Date of Leave End Date of Leave

Employee Signature _____ **Today's Date** _____

Supervisor Signature _____ **Today's Date** _____

☐ Approved ☐ Denied HR Signature & Date:

Change Leave Type/Extending

I am changing my leave type:

- ❑ Child Care Leave to Personal Leave
- ❑ Immediate Family Illness to Personal Leave
- ❑ Medical Leave to Personal Leave
- ❑ Medical Leave to Long Term Disability
- ❑ Medical Leave to Child Care Leave
- ❑ Child Care Leave to Medical Leave
- ❑ **I am not changing my type of leave**

I am requesting to extend/change my leave of absence type starting on _____ **My leave will end on**_____
Start Date of Leave *End Date of Leave*

Employee Signature _____ **Today's Date** _____

Supervisor Signature _____ **Today's Date** _____

☐ Approved ☐ Denied HR Signature & Date:

Returning from Leave

I am requesting to return from my leave of absence. I plan to return on _____ **I have submitted medical documentation as required.**
Return to Work Date

Employee Signature _____ **Today's Date** _____

Supervisor Signature _____ **Today's Date** _____

Revised: 03/04

☐ Approved ☐ Denied HR Signature & Date: