GLENDALE UNIFIED SCHOOL DISTRICT
Certificated Bargaining Unit Request for Leave of Absence

Employee Name: _____ Date of Request: _____

Assignment Location: _____ Position/Title: _____

I request leave for the following purpose (check one):

_____1.	Health Leave (CBA, Section 3)	_____ 8.	Opportunity Leave (CBA, Section 12)
_____2.	Optional Unpaid Pre-Childbirth Leave (CBA, Section 4a)	_____ 9.	Jury Duty and Court Appearance Leave (CBA, Section 13)
_____3.	Pregnancy – Childbirth Disability Leave (CBA, Section 4b)	_____ 10.	Study Leave (CBA, Section 15)
_____4.	Child Care Leave (CBA, Section 4d)	_____ 11.	Travel for Educational Purposes (CBA, Section 16)
_____ 5.	Home Responsibility Leave (CBA, Section 9)	_____ 12.	Legislative Leave (CBA, Section 17)
_____ 6.	Family and Medical Care Leave (CBA, Section 10)	_____ 13.	Conference Leave (CBA, Section 18)
_____ 7.	General Purpose Leave (CBA, Section 11)	_____ 14.	Military Leave (CBA, Section 21)

If you are unsure which box to check, please state the purpose of your leave: _____

_____

Date leave is to begin: _____ Expected duration of leave: _____

Signature of Employee: _____ **Date:** _____

TO THE EMPLOYEE: Where applicable, the granting of leaves of absence is subject to the provisions of the relevant collective bargaining agreement and Board Policies. **Approved leaves will also be credited, as appropriate, to mandatory leave periods defined by Federal and State law, e.g., FMLA, CFRA, and PDL.**

(1) The District may request additional information deemed necessary to process and verify this request.
(2) Completed application forms must be submitted to Human Resources within timelines **specified in the certificated Collective Bargaining Agreement and/or Board Policies.**

Signature of Supervisor: _____ **Date:** _____

FOR DISTRICT HUMAN RESOURCES OFFICE PURPOSES ONLY

_____ Approved _____ Not Approved Signature _____ Date _____

Date Approved by Board _____ Leave Designation _____

Rev. 3/26/12

GLENDALE UNIFIED SCHOOL DISTRICT
Glendale, California

REQUEST FOR FAMILY MEDICAL LEAVE OF ABSENCE (FMLA)

Employee Name: _____ Date of Request: _____

Assignment Location: _____ Position/Title: _____

Hire Date: _____

I request a Family Medical Leave of Absence for the following purpose (check one):

_____ A. The birth of a child and/or in order to care for such child.

_____ B. The placement of a child for adoption or foster care.

_____ C. In order to care for an immediate family member because such family member has a serious health condition. Circle one: CHILD SPOUSE PARENT
(Written certification of a health care provider may be required)

_____ D. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. **(Written certification of a health care provider may be required.)**

NOTE: FMLA runs concurrently with Maternity Leave.

Date leave is to begin: _____ Date leave is to end: _____

If the employee fails to return upon expiration of the leave for a reason other than the continuation, recurrence or onset of a serious health condition which would itself have met the qualifications for family medical leave, then the District may recover health insurance premiums paid pursuant to the Family Care Leave provisions.

For FMLA leave only:
According the Memorandum of Understanding signed by the District and the Glendale Teachers Association on January 6, 2014, the District agreed that "GTA members who are on unpaid FMLA leave may use no more than 15 days of accumulated sick days for pay, but will not be able to go into their 100 days at 50% pay if on CFRA or FMLA. Employees will not be given medical coverage by the District if by law the District has satisfied their yearly responsibility to provide paid medical benefits under PDL, FMLA and CFRA."

_____ Yes, I would like to apply ___ days of accumulated/earned sick leave pay during my FMLA leave.

_____ _____
Employee Signature Date

GLENDALE UNIFIED SCHOOL DISTRICT
Glendale, California

MATERNITY LEAVE OF ABSENCE REQUEST
And
PHYSICIAN'S VERICIATION STATEMENT (PVS-I)

Section I: TO BE COMPLETED BY EMPLOYEE

Employee's Name: _____

Title: _____ School/Work Location: _____

Grade Level/Subjects Taught: _____

Indicate length of maternity leave anticipated: (Check one)

_____ A. For the period of time

Beginning _____ 20___ and

Ending _____ 20___ (inclusive)

_____ B. For the remainder of the school year in which leave becomes effective

Beginning _____ 20___ and

Ending _____ 20___ (inclusive)

And one (1) additional school year.

(**NOTE**: If "b" is checked, a separate letter to the Human Resources Office must accompany this form to request the additional school year of non-pay Maternity Leave of Absence.)

Indicate whether you wish to receive Sick Leave Pay in conjunction with the Maternity Leave of Absence: (Check one)

_____ A. I do not wish to receive Sick Leave Pay in conjunction with my Maternity Leave of Absence.

_____ B. I wish to request Sick Leave Pay in conjunction with my Maternity Leave of Absence for the period of time indicated by my personal physician during which I will be physically unable to perform my regularly assigned work duties.

I agree to the provisions of the Maternity Leave of Absence procedures as set forth in the existing Collective Bargaining Agreement.

_____ _____
Employee's Signature Date

GLENDALE UNIFIED SCHOOL DISTRICT
Glendale, California

MATERNITY LEAVE OF ABSENCE REQUEST
And
PHYSICIAN'S VERIFICATION STATEMENT (PVS-I)

Section II: TO BE COMPLETED BY PRINCIPAL/IMMEDIATE SUPERVISOR

1. Employment hours _____ daily; _____ days per week

2. Specify employee's duties (brief position description, include Science Lab or Art classes, if applicable)

_____

_____

_____

3. List any regularly assigned special duties (Example: Playground supervision, extra curricular duties, etc.)

_____

_____

_____

4. Describe work location (Example: Regular classroom, single story building, etc.)

_____

_____

_____

5. Describe physical activities required of employee during regular assignment (Example: Stair climbing, lifting, etc.)

_____

_____

_____

_____
Employee's Name

_____ _____ _____
School/Work Location Principal/Supervisor Signature Date

GLENDALE UNIFIED SCHOOL DISTRICT
Glendale, California

MATERNITY LEAVE OF ABSENCE REQUEST
And
PHYSICIAN'S VERIFICATION STATEMENT (PSV-I)
MEDICAL VERIFICATION OF PREGNANCY

Section III: NOTE TO ATTENDING PHYSICIAN

_____, An employee of the Glendale Unified School District
(Employee's Name)
has requested a Maternity Leave of Absence. Employees are required to accompany this request for maternity leave with a verification statement completed by the attending physician in order to be granted sick leave pay under the provisions of the Policy.

The attending physician must specify the **exact date** the employee shall be released from her position because she is unable to perform assigned duties because of pregnancy. The physician's determination of the period of time the employee is able to perform all of the assigned duties required of her position should take into account the factors of employment as described in Sections I and II of this form.

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Patient's Name _____

School/Work Location _____

Expected Date of Leave: from _____ to _____(inclusive)

Expected Date of Delivery: _____

I understand that the above named patient is assigned as _____
(position held by employee)
whose employment duties are described in Sections I and II.

It is my opinion that certain health and safety hazards that may exist at the previously described work location would not be detrimental to her condition at this time.

In the absence of unexpected complications, her usual occupation can be performed until _____.
(date prior to delivery)

_____ _____
Attending Physician (PRINT NAME) Signature of Attending Physician

_____
Address City Zip Code

(___) _____ (___) _____
Telephone No. Fax No.

GLENDALE UNIFIED SCHOOL DISTRICT
Glendale, California

POST DELIVERY PHYSICAL REPORT
PHYSICIAN'S VERIFICATION STATEMENT (PVS-II)

This form is to be submitted by the employee to the District Human Resources Office four weeks after delivery or miscarriage, and not more infrequently than every two weeks thereafter until such time as the employee is physically able to return to regular assigned duties as indicated in Physician's Verification Statement, PSV-III.

Name of Patient: _____

School/work Location: _____

Delivery or Miscarriage Date: _____

It is my opinion that the above named patient is **physically unable** to perform her regularly assigned duties because of post pregnancy conditions until _____ (Approximate Date) _____. (Inclusive)

_____
Attending Physician (PRINT NAME)

_____ _____
Signature of Attending Physician Date

_____
Address City Zip Code

_____ _____
Telephone No. Fax No.

(Additional copies of this form may be needed by the employee. They may be obtained by calling the District Human Resources Office, 241-3111, ext. 256.)

GLENDALE UNIFIED SCHOOL DISTRICT
Glendale, California

CLEARANCE TO RETURN TO WORK
PHYSICIAN'S VERIFICATION STATEMENT (PVS-III)

This form is to be submitted to the school District physician prior to the employee's return to her school/work location.

Name of Patient: _____

School/Work Location: _____

Delivery or Miscarriage Date: _____

It is my opinion that the above named patient is **physically able** to perform her regularly assigned duties because of post pregnancy conditions until _____ (Inclusive).

_____
Attending Physician (PRINT NAME)

_____ _____
Signature of Attending Physician Date

_____
Address City Zip Code

_____ _____
Telephone No. Fax No.

Date received in Human Resources: _____

_____
Signature: Director, Human Resources