

Greeneville City Schools Request for Leave of Absence

Please contact Human Resources at (423) 787-0976 regarding completion of this form. **Fill out marked sections and return to HR.**

Employee Name: _____
Request Date: _____
Position: _____

Employee SS# XXX-XX-_____
Employment Date: _____
School/Location: _____

LEAVE OTHER THAN FAMILY AND MEDICAL LEAVE UNDER FMLA (Professional personnel only)

As required in GCS Board Policy 5.304, this request is being made for a leave of absence for (select one of the following)
____ Military Service ____ Legislative Leave ____ Maternity (other than FMLA) ____ Adoption (other than FMLA)
____ Recuperation of Health ____ Visitation of Spouse, Child, or Parent Deployed for Military Duty as outlined in 5.304

Anticipated first date of absence _____ Anticipated end of leave date _____

Please indicate the type of leave and number of days to be used for the above period:
____ Sick Leave ____ Maternity/Adoption Leave (beyond FMLA) ____ Personal Leave ____ Vacation
____ Professional Leave ____ Military Leave ____ Sabbatical Leave ____ Legislative Leave ____ Leave without Pay

I intend to return to my position and understand that if I should decide not to return, I must notify the Director at least thirty (30) days prior to the above return date or I will be in breach of contract. I also understand that all leave will be addressed as outlined in the Employee Handbook and GCS Board Policy.

Employee Signature: _____ Date: _____
Approved by Principal/Supervisor: _____ Date: _____
Approved by Director of Schools: _____ Date: _____

FAMILY AND MEDICAL LEAVE UNDER FMLA (For all employees eligible as defined in GCS Board Policy 5.305.)

As required in GCS Board Policies 5.302 and 5.305, this request is being made for a leave of absence (select one of the following):

- ____ for the birth of a child
- ____ to care for a newborn child
- ____ for the placement of a child for adoption or foster care
- ____ to care for a spouse, son, daughter, or parent with a serious health condition
- ____ for a serious health condition that makes employee unable to perform the functions of the employee's job
- ____ for a qualifying exigency due to the fact a spouse, son, daughter, or parent is a covered military member on active duty

Anticipated first date of absence _____ Anticipated end of leave date _____

Please indicate the type of leave and number of days to be used for the above period:
____ Sick Leave ____ Personal Leave ____ Vacation ____ Bereavement ____ Leave Without Pay ____ Comp Time

I understand that medical certifications may be required. I also understand that all medical leave qualifying under FMLA for eligible employees will be addressed or outlined in the Employee Handbook and GCS Board Policy.

Employee Signature: _____ Date: _____
Approved by Principal/Supervisor: _____ Date: _____
Approved by Director of Schools: _____ Date: _____

Revised January 30, 2015

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Return this form to Shelly Smith, KLCO