Berkeley Unified School District
Human Resources Department
2134 Martin Luther King Jr. Way, Berkeley, CA 94704
Telephone (510) 644-6150 Fax (510) 644-6151

REQUEST FOR LEAVE

Section I – Employee

Last Name	**First Name**
Address	
City	**State** **Zip**
Position/Title	**Current FTE%**
❒ **Certificated**	❒ **Classified**
Email Address:	
District ID number	**OR Last four digits of Social Security Number**
Work Phone Number	**Work Location**
Home Phone Number	

Date Requested	**Month**	**Day**	**Year**
Leave Starts			
Leave Ends			

INSTRUCTIONS

For your leave request to be considered, please ensure the following is completed at least 15 work days prior to the leave date requested:

Refer to your union agreement, if applicable, for benefits provided for each type of leave.

Complete Section 1.

For pregnancy, maternity, paternity, sick, extended sick or Family Medical Leave, have a licensed health care provider complete Section II on the reverse side of this form.

For adoption, have the attorney or authorized agent complete Section II on the **reverse side of this form**.

After all of the appropriate sections of the form are completed, submit this request to your supervisor for review.

Your supervisor completes Section III **on the reverse side of the form** and forwards the leave request to the Human Resources Department for action.

To ensure your leave balances and pay are accurate, promptly submit to the Human Resources Department, Absence Certificates for all of your absences.

Leave Requested:

❒ 100% leave or ❒ _____% Leave

❒ Pregnancy Leave

❒ Maternity/Paternity/Child Rearing Leave

❒ Family Medical Leave (FMLA)

❒ Adoption Leave

❒ Military Leave (Attach Orders)

❒ Sick Leave

❒ Extended Sick (After other paid leave is exhausted)

❒ Unpaid Leave
Explanation:
_____
_____

I certify that the reason(s) specified above are true and correct.

Signature ***Date***

Section II Physician's or Attorney's Verification

A physician's verification is required for leaves such as pregnancy, maternity, paternity, sick leave, extended sick or Family Medical Leave. An attorney's verification is required for adoption leave.

Employee's Last Name Employee's First Name	**Date of health condition, expected delivery or adoption:**

Reason for Leave:

❒ I have attached documentation to justify reason(s).

This does not constitute a medical release. *A SEPARATE MEDICAL RELEASE IS REQUIRED BEFORE THE EMPLOYEE CAN RETURN TO REGULAR DUTY.*

Name of Physician or Attorney:	**Anticipated date employee will be able to return to full duty:**

Office Address City State Zip	**Office Telephone Number:**

Physician's or Attorney's Signature:	**Date:**

Section III Immediate/Program Supervisor's Review

I certify that all absence certificates for this employee have been submitted to the Human Resources Department.

❒**Leave Recommended** ❒**Leave Not Recommended**

Supervisor's Name	**Signature**	**Date**

Section IV Approved: ❒Yes ❒No

Director, Classified Personnel	**Date**	**Director, Personnel Services**	**Date**
HR Staff replied to employee and employee's supervisor:	**Date**	**Method of Communication:**	**HR Staff:**