WASHINGTON TOWNSHIP PUBLIC SCHOOLS

Family Leave / Medical Leave / Child Care Leave/ Sick Leave/ Sabbatical/ Unpaid Leave

Leave Information

Employee Name:

Address:

Position: Location:

Anticipated leave Date Anticipated Return Date:

Type of Leave Requested: (mark all that apply)

** ☐ N.J. Family or Federal Medical Leave Act _____ Number of Weeks requesting (up to 12 weeks)

** Types of Leaves POLICY # 3431.1

Birth or Placement of Child
Serious health condition of Family Member
Serious health condition for Self

☐ Maternity If paid maternity disability, number of weeks requesting _____(up to 8 weeks)

☐ Child Care ☐ Adoption / Foster Care ☐ Dependent Care

☐ Medical/sick Leave ☐ Sabbatical ☐ Unpaid Leave

Reason for Leave: *Please attach reason/Medical Documentation to support your request **(please attach)**

( ) I have received a leave before Dates of Previous Leave:
( ) I have not received a leave before

Completed by Human Resources Department

☐ Paid Disability	Begin Date:	End Date:
☐ Personal Day Bank	Begin Date:	End Date:
☐ Paid Sick Days	Begin Date:	End Date:
☐ Family Leave	Begin Date:	End Date:
☐ Sabbatical Leave	Begin Date:	End Date:
☐ Unpaid Leave	Begin Date:	End Date:
Return Date: (as per contract)		

If any clarification is needed concerning completion of this form or eligibility, please contact Human Resources at Ext. #6604.

Employee Signature	*Date*
Principal / Supervisor Signature	*Date*

CC: Payroll
Revised 04/19/12

Board Approval Date _____