PARAMUS PUBLIC SCHOOL DISTRICT
REQUEST FOR LEAVE OF ABSENCE (including FFCRA)

Name_____ Date_____

Position _____ Building _____

USE OF ACCRUED DISTRICT PAID LEAVE:

Sick days*: From _____ To _____ _____ Total # of Days

Personal days: From _____ To _____ _____ Total # of Days

Vacation days: From _____ To _____ _____ Total # of Days

Floating Holidays From _____ To _____ _____ Total # of Days

(* Use of district paid sick days may require supporting medical pursuant to district policy/practice.)

MATERNITY OR CHILD REARING LEAVE

(To be completed **ONLY** if employee is not eligible for statutory family leave)

Dates: From _____ To_____

Request to be submitted three (3) months in advance

FEDERAL EMERGENCY PAID SICK LEAVE ACT

(F/T: UP TO 80 HOURS; P/T: UP TO AVG. WEEKLY HOURS WORKED X 2 WEEKS)

I, _____, am unable to work, including by means of tele networking.
(Employee's Full Name)

REASON (Check one):

☐ Subject to Federal/State/Local COVID-19 Quarantine or Isolation Order.

☐ Caring for Individual Subject to Federal/State/Local COVID-19 Quarantine or Isolation Order.
Person's Name_____ **Relationship to Employee**_____

☐ Advised by Health Care Provider to Self-Quarantine Due to COVID-19 Concerns.

☐ Experiencing COVID-19 Symptoms and Seeking Diagnosis.

☐ Caring For Child While School/Care Center Closed or Care Provider N/A for COVID-19 Precautions.

Child's Name_____ **Age**____ **School/Childcare Name**_____
Child's Name_____ **Age**____ **School/Childcare Name** _____
Child's Name_____ **Age**____ **School/Childcare Name** _____
Child's Name_____ **Age**____ **School/Childcare Name** _____

I, _____, affirm that there are special circumstances for any child
(Employee's Full Name)
listed above age15 or older.

☐ Experiencing substantially similar condition specified by USDOHHS.

DATES: FROM: _____ TO: _____ TOTAL # OF HOURS/DAYS _____

PARAMUS PUBLIC SCHOOL DISTRICT
REQUEST FOR LEAVE OF ABSENCE (including FFCRA)

STATUTORY FAMILY LEAVE

Request must be submitted thirty (30) days in advance in order to obtain approval for a period of leave up to twelve (12) weeks in any twelve (12) month period.

Have you been employed by the district for at least twelve (12) months and have worked at least 1,000 hours (NJFLA) and/or worked 1250 hours if applying for federal leave (FMLA) in the preceding twelve (12) month period?

Yes _____ No _____

Have you taken a leave within the last twenty-four (24) months? Yes _____No _____

Current request for:

A. **Serious health** condition of: (circle one) **yourself** (FMLA) or **family member** (NJFLA & FMLA)

If family member, relationship _____
Dates: From _____ To_____

For a serious health condition, the medical certification should indicate the following:
***Date on which the serious medical condition commenced * Probable duration of the condition**
*** Medical facts within the provider's knowledge regarding condition**

Is medical certification attached? Yes _____ No _____

If not, date on which certification is to be submitted _____

B. **New Child Bonding (NJFLA & FMLA)** – Dates: From _____ To: _____

Is certification attached stating date of birth or date of placement of child, whichever is appropriate?

Yes _____ No _____ If not, date on which certification is to be submitted _____

C. **Public Health Emergency** (Expanded FMLA; Requires ONLY district employment for thirty (30) calendar days):

* To care for minor child, if school/care center is closed or care provider is unavailable due to a public health emergency related to COVID-19 declared by federal/state/local authority.

Dates: From _____ To: _____
(Note: First ten (10) days of leave for this reason are unpaid; thereafter, leave for this reason partially-paid per statute.)

PARAMUS PUBLIC SCHOOL DISTRICT
REQUEST FOR LEAVE OF ABSENCE (including FFCRA)

MEDICAL LEAVE

Dates: From _____ To_____

Please attach a physician's note indicating the following:

1. Date on which the medical condition commenced
2. Probable duration of the condition
3. Medical facts indicating applicant's inability to perform contractual duties

Medical certification has been submitted:

Yes _____ No _____ If not, date on which physician's note is to be submitted _____

*Upon return to work, the employee must submit a physician's note indicating the ability to perform his or her job responsibilities.

PERSONAL LEAVE (NON-MEDICAL)
[NOTE: LEAVE BEYOND FRINGE ENTITLEMENTS IS UNPAID/WITHOUT BENEFITS AND REQUIRES SUPERVISOR'S RECOMMENDATION]

Dates: From _____ To_____

Reason:
_____

Is a separate request letter attached? Yes _____ No _____

_____ _____
Signature of Staff Member Date

_____ _____
Signature of Program Administrator Date