Revised 6/2024

BALDWIN COUNTY BOARD OF EDUCATION
LEAVE-OF-ABSENCE REQUEST

PART I

HR Office Use ONLY!!
Agenda □ Addendum □
Board Date_____
Approved □ Disapproved □
HR Administrator_____

Employees who have a foreseeable absence of two weeks or longer (more than ten (10) workdays) are required to request an official leave of absence to be submitted for Board consideration. All LOA requests should be submitted to the HR office at least TWO WEEKS PRIOR to the first date of the employee absence and supporting documentation must be attached. Unforeseeable LOA requests and supporting documentation should be forwarded to the HR office as soon as it is determined there is a need for leave.

Name _____ EmpNo _____ Home phone_____

School/Site_____ Position/Grade/Subject_____

Hours/Day_____ Calendar/Job Days_____

Reason for Request ☐ Medical ☐ Family Medical ☐ Maternity ☐ Prof Study ☐ Personal ☐ Military
(Choose one)

Dates Requested_____ _____
Approximate Beginning A date is **REQUIRED**
Anticipated Return Please **DO NOT list unknown or leave blank** A date is **REQUIRED**

SUPPORTING DOCUMENTATION BELOW MUST BE ATTACHED FOR REVIEW BY HUMAN RESOURCES:

- Medical Leave (employee, employee's spouse or family member) – medical verification issued by the appropriate health care provider that includes the beginning date of leave and an expected date of return
- Professional Study Leave –a copy of official registration/course schedule information from college/university
- Personal Leave for an extended period – a detailed explanation from the employee explaining the need for leave
- Military Leave – a copy of orders

By signing below, I acknowledge that it is my responsibility to review and be in compliance with board policy in regard to my leave-of-absence.

_____ _____ _____
Employee Signature Date Principal/Supervising Administrator Signature

Board Policy 5.12.2
Employees who know in advance that they will be absent from work must notify the Board of the expected absence in accordance with procedures specified by the Superintendent or the Board. In the event of an emergency or incapacity that makes advance notice impractical, employees must notify the Board of their absence as early as possible.

Employees who have a foreseeable absence of two weeks or longer (more than ten (10) workdays) are required to request an official leave of absence for Board consideration. Leaves of absence, paid or unpaid, may be requested for up to one year. Leave of absence requests shall be approved on a case by case basis. No employee, except as otherwise provided under applicable law, is guaranteed or entitled to a leave of absence. Leave of absence requests for medical reasons of an employee or an employee's spouse or family member must be supported by medical verification issued by the appropriate health care provider and include an expected date of return. The Board may require an employee who has taken leave due to medical reasons to provide the Board with a healthcare provider's certification in form acceptable to the Superintendent in order to return to work.

Employees are not allowed to take unpaid leave at their discretion. Unpaid leave is not allowed unless an employee obtains prior approval by the Board and/or unless unpaid leave is provided for under applicable State or Federal law.

Except as otherwise provided or permitted, an employee who is absent from work without approved leave will be considered absent without leave in violation of Board policy and subject to appropriate disciplinary measures. Employees who are approved for paid leave or absences will be paid at the regular daily rate of pay; however, a day of paid leave or absence will not be counted as a day worked for the purposes of computing overtime under the Fair Labor Standards Act. Leaves or absences not covered by sick, annual, personal, or other appropriate form of paid leave will be unpaid. Associated reductions in pay will be administered in accordance with payroll procedures. The continuation of benefits during an approved absence is subject to the provisions of the particular benefit policy or plan.

BALDWIN COUNTY BOARD OF EDUCATION
LEAVE-OF-ABSENCE FORM

PART II

COMPLETE THE LAST DAY WORKED PRIOR TO LEAVE

Name _____ EmpNo _____

School/Site _____ Position/Grade/Subject _____

Last Date Taught/Worked_____ Anticipated Return Date _____

If request is due to **Military leave**, please indicate the number of days below you wish to utilize, if applicable:
PERSONAL____ANNUAL____COMP____

The Board may require an employee who has taken leave due to medical reasons to provide the Board with a healthcare provider's certification in a form acceptable to the Superintendent in order to return to work. In these cases, the HR office should receive medical verification certifying the employee is cleared to return to work. This should be received in the HR office PRIOR to the employee's first day back.

By signing below, I understand that if required, it is my responsibility to provide the HR office with the appropriate medical certification prior to returning to work from my leave-of-absence.

_____ _____ _____
Employee Signature Date Principal/Supervising Administrator Signature

BALDWIN COUNTY BOARD OF EDUCATION
LEAVE-OF-ABSENCE DATE OF RETURN FORM

PART III

COMPLETE THE DATE OF RETURN

Name _____ EmpNo_____

School/Site _____

Position/Grade/Subject _____

Date Returned_____

By signing below and if applicable, I acknowledge that I have provided the HR office with medical verification certifying that I have been cleared to return to work.

_____ _____ _____
Employee Signature Date Principal/Supervising Administrator Signature

Forward to the Office of Human Resources Immediately Upon Return to Work

The Board may require an employee who has taken leave due to medical reasons to provide the Board with a healthcare provider's certification in a form acceptable to the Superintendent in order to return to work.

Revised 06/2024

BALDWIN COUNTY BOARD OF EDUCATION

HR Office Use ONLY!!
Agenda □ Addendum □
Board Date_____
Approved □ Disapproved □
HR Administrator_____

LEAVE-OF-ABSENCE REQUEST FOR AN EXTENSION

Please extend my leave through the date listed below.

Name _____EmpNo _____

School/Site _____

Position/Grade/Subject _____

Hour/Day_____ _____ Calendar _____

Reason for Request_____ **New Anticipated Return Date**: _____
(Medical, Family Medical, Maternity, Prof Study, Personal, Military) A date is **REQUIRED**

SUPPORTING DOCUMENTATION BELOW MUST BE ATTACHED FOR REVIEW BY HUMAN RESOURCES:

- Medical Leave – a physician's statement indicating the need for leave and a designated date of return to work
- Professional Study Leave –a copy of official registration/course schedule information from college/university
- Personal Leave for an extended period – a detailed explanation from the employee explaining the need for leave
- Military Leave – a copy of orders

_____ _____ _____
Employee Signature Date Principal/Supervising Administrator Signature

Rev. 7/25/2024

BALDWIN COUNTY BOARD OF EDUCATION
CATASTROPHIC SICK LEAVE REQUEST

Catastrophic Sick Leave is approved only when an employee is away from his/her duties for a period of 30 consecutive calendar days as verified by a physician on a Medical Verification of Catastrophic Illness form.

With this request you must provide a **Medical Verification of Catastrophic Illness** completed by a physician. If approved, you must obtain and submit completed Catastrophic Sick Leave Transfer Authorization forms reflecting donated leave.

Note: If your request for catastrophic leave is approved, donated days will not be applied until your available sick leave, to include 10 days borrowed from the Sick Leave Bank, your two state allocated personal leave days, and annual days if applicable, have been used. These days will automatically be applied to your absences before donated sick leave will be applied.

(Please type or print legibly)

Name: _____ Social Security Number: ***-**-_____

Employee Number: _____ Base School/Station: _____

Position: _____ Home Telephone Number: _____

Home Address: _____

CITY: _____ STATE: _____ ZIP: _____

I request approval of Catastrophic Sick Leave and application of donated sick leave days to my days absent from work. I understand that should I return earlier than the number of days donated, the remaining days will be returned to donors. I also understand that before I can receive donated days, any available sick leave, 10 days from the sick leave bank, my two state personal leave days, and any annual leave if applicable, will be used first.

_____ _____

SIGNATURE OF EMPLOYEE REQUESTING LEAVE DATE

Send Completed Form to: Baldwin County Board of Education
Attn: Human Resources Department/Catastrophic Leave Request
2600-A North Hand Avenue
Bay Minette, AL 36507
eMail to: Amanda Barber/ abarber@bcbe.org

(For Payroll Office Use Only)

Date Submitted to Sick Leave Bank Committee: _____

Sick Leave Bank Committee Recommends: ☐ **Approval** ☐ **Denial**

Asst. Superintendent Human Resources:_____ Date: _____

Processed By Payroll Specialist: _____ Date: _____

Rev. 04/21/2022

BALDWIN COUNTY BOARD OF EDUCATION LEAVE OF ABSENCE MEDICAL VERIFICATION

To be completed by a physician and submitted with the appropriate leave of absence request. This is a required form for all Leave of AbsenceRequests & Catastrophic Illness Requests.

Please supply all requested information. Attach additional sheets if more space is needed to fully explain condition.

(Please type or print legibly)

Name:_____Social Security Number: ***-**-_____DOB:_____

Employee Number:_____Base School/Station: _____

Position:_____Home Telephone Number: _____

Home Address: _____

CITY: _____ STATE: _____ ZIP: _____

Date illness/injury began:_____Likely or anticipated, **duration** of the condition, illness or injury _____

Likely or anticipated **Return to Work Date (Specific Date Required)**: _____

Is this a catastrophic illness/injury? **YES** **NO**

*A "Catastrophic Illness" is defined as any illness, injury, or pregnancy or medical condition related to childbirth, certified by a licensed physician which causes the employee to be absent from work for an extended period of time, i.e. at least 30 consecutive calendar days.

Appropriate medical facts within the knowledge of the physician to substantiate the medical condition requiring a leave of absence, and if catastrophic, to substantiate the serious medical condition or catastrophic illness/injury: **(Attach additional sheets if more space is needed.)**

_____

_____

If employee is to care for sick spouse, child or parent, state conditions/reasons why employee must care for this person:

_____

_____

Due to the employee's health condition, and your understanding of the employee's job functions, is this employee able to perform the essential functions of the job? ☐ **YES** ☐ **NO**

If **NO**, can he/she do so with accommodations? ☐ **YES** ☐ **NO**

If **YES**, suggested accommodations: _____

Name of Physician:_____Office Telephone: _____

Name of Practice/Medical Specialty: _____

Office Mailing Address: _____

City:_____State:_____Zip: _____

By my ***signature***, I verify the employee named above is incapacitated due to the health condition, illness, or injurydescribed above, and thereby unable to perform his/her job during the stated time period.

_____ _____

Signature of Heath Care Provider **(Stamps NOT accepted.)** **Date**

BALDWIN COUNTY BOARD OF EDUCATION
CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

Donating Employee Information

Donor Employee Name: _____

Social Security Number: _____ **Employee No.** _____

Employee Address: _____

Employee Telephone: _____

Employer: _____

I authorize the transfer of _____ number of sick leave days **(not to exceed 30 days)** from my accumulated sick leave to the beneficiary named below. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his or her use due to a catastrophic illness as defined by Act 95-386 which amends Section 16-22-9 of the Code of Alabama. I understand these days will not be returned to me unless beneficiary does not use them.

_____ _____

Donor Employee's Signature Date

Beneficiary Employee Information

Beneficiary Employee Name: _____

Social Security Number: _____

Beneficiary Employee's Employer: _____

Donor's Employer Authorization:

I certify the donor employee named above has sufficient sick leave days to donate the number of days indicated and that the information listed above is correct to the best of my knowledge.

Authorized Signature: _____

Title: _____ Date: _____

Receipt of Beneficiary Employer:

The above noted number of sick leave days have been credited to the sick leave account of the beneficiary employee. (Please give a copy of this form to the beneficiary employee.)

Authorized Signature: _____ Date: _____

PLEASE SEND FORM TO: BALDWIN COUNTY BOARD OF EDUCATION
PAYROLL DEPARTMENT – SICK LEAVE
2600-A NORTH HAND AVENUE
BAY MINETTE, AL 36507

Fitness-for-Duty Certification Form

LOA/OJI/ADA

Employee Information		
First Name	MI	Last Name
Department		Immediate Supervisor

Health Care Provider
Please indicate the status for the employee's return to work status:
☐ The employee is able to return to work with no restrictions.
☐ The employee is able to return to work with the following restrictions:
☐ The employee is unable to return to work based on the attached job description.

Return to work effective date:	
Name of Health Care Provider:	
Specialty:	
Address:	
Phone Number:	

_____ _____

Signature of Health Care Provider Date

INSTRUCTIONS TO EMPLOYEE

Please complete and return this form to your **immediate supervisor** and **Human Resources** prior to or on the day in which you will return to work.