CONFIDENTIAL LEAVE REQUEST

HARTFORD Public Schools
CHOOSE. ACHIEVE. SUCCEED.

Employee Name _____ **Employee Number** _____

Position Title _____ **Location/Department** _____ **Bargaining Unit Affiliation** _____

Request WITH PAY [ ]

☐	411	SICK (to extent accrued)
☐	431/418	PERSONAL (to extent accrued)
☐	421	VACATION (to extent accrued)
☐	488	FLOATING HOLIDAY
☐	451	PROFESSIONAL LEAVE (Article____)*
☐	403	ADOPTION FROM SICK (Article____)*
☐	413	CHILD BEARING (maternity) (Article____)*
▶☐	461	UNION LEAVE (Article____)*
▶☐	464	MILITARY LEAVE (Article____)* (non-professional employees eligible only – for less than 30 days)
▶☐	453	SABBATICAL (Article____)*

Request WITHOUT PAY [ ]

▶☐	847	CHILD REARING WITHOUT PAY (Article____)*
▶☐	891	HARDSHIP LEAVE WITHOUT PAY (Article____)*
▶☐	854	SABBATICAL WITHOUT PAY (Article____)*
▶☐	842	LEAVE WITHOUT PAY (due to personal reasons)
▶☐	890	LEAVE WITHOUT PAY (due to illness)
▶☐	841	VACATION WITHOUT PAY
▶☐	892	FAMILY MEDICAL LEAVE (FMLA) WITHOUT PAY (eligibility determined by law) (may run concurrently with other leaves)
▶☐	845	MILITARY LEAVE WITHOUT PAY
☐	499	JURY DUTY (may be paid depending on law & contract)

* Must list contract provision where indicated by (Article____)*.

▶ ***REQUESTS INDICATED BY AN ARROW (▶) MUST BE APPROVED BY THE HUMAN RESOURCES / LABOR RELATIONS DEPARTMENT.***

The Hartford Board of Education reserves the right to request medical records in the event of a sick leave. If your leave is for more than five consecutive days, a doctor's note is required. Please have your doctor complete the back of this form.

FROM (first date absent): _____ (Day of the Week) ____/____/____ (Date)

TO (date to return): _____ (Day of the Week) ____/____/____ (Date)

Number of Days Requested: _____ **Number of Hours Requested:** _____

Explanation/Comments: _____

_____

Prepared By: _____ **Date:** _____

Employee Signature: _____ **Date:** _____

Dept. Administrator/ Principal Approval: _____ (*Signed*) **Date:** _____ [ ] Recommend Approval [ ] Recommend Non Approval

HR/Labor Relations: _____ (*Signed*) **Date:** _____ [ ] Approval [ ] Non Approval

Approval With Pay [ ] **Approval Without Pay [ ]** **Not Approved [ ]**

Send a copy of this form for leaves of more than 5 days and any request for day(s) without pay to the Human Resources Department. Any forms not approved by the supervisor must be sent to the Human Resources Department.

HARTFORD BOARD OF EDUCATION - CONFIDENTIAL LEAVE REQUEST

Certificate of Health Care Provider

1. Employee's Name
2. Please, state diagnosis of patient. Describe medical facts related to patient's condition.
3. Is the patient unable to perform work of any kind, due to the above-stated medical conditions?
4. If yes, state the probable duration of the patient's inability to work.

Name of Health Care Provider (typed/printed)

Signature of Health Care Provider

Type of Practice

Address

( )

Telephone Number

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