



Request for Leave of Absence FANS

Email to: MTALLEY@greenville.k12.sc.us
Fax to: 864-355-9314

If you are unable to work due to *illness or injury five consecutive days OR more*, you are required to submit this request. You may also use this form for illnesses under FMLA that require *intermittent leave*. This request should be provided to your supervisor in advance or no later than the sixth work day of your absence. If you are unable to submit this form on time, please contact your supervisor or Human Resources for assistance. (Supervisor – if employee is unable to complete the request form due to illness, please submit the form with known information).

PART I: EMPLOYEE STATEMENT (please PRINT)

Name: Last, First, Middle Initial				
Address: Street		City	State	Zip Code
Home Phone:	Cell phone:	Employee Number		
Last Day Worked	Is this Work Related?	Will this illness require intermittent absences?		
Date of Estimated return to work (if intermittent give estimated ending date)				
Description of illness or injury (attach physician's statement)(if absence for family member list name, relationship)				
School/Department	Current Job	Supervisor's Name		

By my signature below, I certify that the above facts are true and accurate.

I understand in order to *continue to use paid sick leave*, I must present a doctor's certification no later than the sixth consecutive workday during my absence because of this illness. I understand by not providing a doctor certification by the sixth day that this could be an unpaid leave until certification is received.

I understand that this leave of absence could qualify for FMLA Leave. If FMLA eligible, I will be notified in writing. To be eligible for FMLA, an employee must have worked for Greenville County Schools for at least 1 year and 1,250 hours the previous 12 months and *not have used his FMLA benefit in the previous 12 months.*

I understand that if my leave is unpaid, it is my responsibility to contact the Benefits Department (355-1188) to make payment arrangements for the employee portion of my insurance coverage during my leave.

I understand that if my leave period will exceed 90 days it is my responsibility to contact the Benefits Department as soon as possible to discuss my eligibility for disability benefits.

I understand that it is my responsibility to contact my supervisor during any approved leave of absence. Failure to contact my supervisor at the expiration of a leave may result in termination of my employment.

I understand in order to return to work, I must provide a doctor's release to return or if returning with restrictions to have prior approval before returning.

I understand if this leave should need to go beyond the original request, I need to submit a request for an extension as well as providing doctor's certification to support an extended leave.

Employee's Signature Date _____
Supervisor's Signature Date

EXTENSION: Estimated Date of Return: _____
Documentation is required to be provided to request an extension to Leave.