

APPLICATION FOR LEAVE WITHOUT PAY

Name: _____ S.S.#: _____

Address: _____ Phone: _____

Work Location: _____ Assignment: _____

Period for which leave is requested:

Beginning Date: _____ Ending Date: _____

Reasons for which a leave without pay may be granted: (✓) Check One

- _____ Child Care
- _____ Personal Illness
- _____ Family Illness
- _____ Death in the Immediate Family
- _____ Educational Development
- _____ Cultural Development
- _____ Community or Professional Service
- _____ Personal

**USE THIS SPACE TO EXPLAIN
YOUR REASON FOR A LEAVE
WITHOUT PAY**

GUIDELINES:

1. Your explanation for the above reasons must accompany your request. Additional information may be required.
2. Leave without pay shall not be granted in order to work in another school system or to be employed full time.
3. The Superintendent must approve early return from leave without pay.

I _____ do hereby understand and shall abide by the provisions stated above. I also understand that in the event that I fail to comply with the provisions stated under the guidelines above that my leave without pay shall be terminated.

Signature

Date

**PLEASE CONTACT THE PAYROLL/INSURANCE DEPARTMENT TO DISCUSS
ANY POSSIBLE BENEFIT CHANGES.**

Submit original form to Superintendent