Form A--Application for Extended Leave

Extended leaves are those expected to last more than 3 consecutive working days. You must notify the APS Human Resources Extended Leaves Office **at least thirty (30) days prior to the commencement of** your extended leave of absence. Union contract and applicable Federal and State law govern these leaves. Your eligibility for leave will be determined after receiving this form and all relevant supporting documentation. Your leave **will not** be **accepted** until complete. You will be notified of your leave status by mail.

Leave Information -- Print Legibly

Name: _____ Employee # _____

Address: _____ Job Title: _____

City, Zip _____ Site Supervisor: _____

Home #: _____ Cell #: _____ Site Payroll Person: _____

Loc. #_____ Location Name: _____

Do you qualify for Sick Leave Bank? ☐Yes ☐No Is this a continuation from Sick Leave Bank? ☐Yes ☐No

If you need to apply for Sick Leave Bank…STOP!

If you intend to apply for Sick Leave Bank benefits, complete the SLB Application and SLB Physician's Statement

Period of Leave Requested

Requested Leave Start Date: _____ Expected Return to Work Date: _____

Type of Leave You Are Requesting

☐Advance Study Leave (Unpaid)	Form A and letter of acceptance, class schedule, and grades for prior semester, (if applicable)
☐Assault Leave	Form A and police report, and health care provider certification, employees also complete First Report of Injury and contact Risk Management at 830-8466
☐Domestic Violence Leave	Form A and legal documentation
☐Illness in the Immediate Family	Form A and Family-Certification of Health Care Provider
☐Injury or Illness of Military Member	Form A and WH385
☐Intermittent Leave	Form A and Employee or Family-Certification of Health Care Provider
☐Medical Leave	Form A and Employee-Certification of Health Care Provider
☐Military Service Leave	Form A and military orders or commander's letter
☐Parental Leave (Birth of a child)	Form A and Employee-Certification of Health Care Provider
☐Parental Leave (Non-Birth Only)	Form A and Family-Certification of Health Care Provider, child's birth certificate, or legal documentation of adoption or foster placement (documentation depends on situation)
☐Part-time Leave	Form A and Statement Page (A Schedule Only--no supervisor signature required)
☐Personal Leave (Unpaid)	Form A and Statement Page signed by supervisor (A, B, G/H Schedule employees do not need supervisor signature)
☐Political	Form A and confirmation of appointment
☐Qualifying Exigency	Form A and Form WH 384
☐Union Leave	Form A and name of Union you will represent _____

Medical Release will be required to reinstate from medical leave.

Refer to the Negotiated Agreement and/or Leaves Specialist regarding the use of available paid leave. **For Medical Leave** (for your *own* illness or injury), the district will exhaust all your available leave balances. Your available leave will be used in this order: sick leave, personal days, and annual leave. In qualifying circumstances, employees requesting extended leave will be able to use their available balances that have accrued up until the start of the leave. Absences balances will cease to accrue once an employee is in an unpaid status.

For **Illness in the Immediate Family Leave**, the district will exhaust your Sick leave accrual, personal leave, and annual (if available). After these accruals are exhausted, the remainder of your leave will be unpaid.

Sign this form**.** Attach appropriate documentation. Return this packet to Extended Leaves Office in person or by US Mail. PO Box 25704, Albuquerque, NM 87125-0704. If you have questions, please contact the Leave Specialist at **889-4808 (A-L) or 889-4865 (M-Z).**

_____ _____

Signature Date

ALBUQUERQUE PUBLIC SCHOOLS

FAMILY MEMBER

Certification of Health Care Provider for
Family Member's Serious Health Condition

Employee Name: _____

Employee Address: _____

Employee ID Number: _____ Employee's Job Title: _____

- Family Member's Name: _____
- Relationship of family member to employee: _____
- If son or daughter, date of birth: _____

Instructions for the Health Care Provider: The employee listed above has requested a leave of absence for care for your patient. Limit your responses to the condition for which the employee is seeking leave. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine coverage.

1) Dates you treated the patient for this condition: _____

_____

2) Is the medical condition a pregnancy? No☐ Yes☐ Expected delivery date_____

3) Will the patient be incapacitated for a single continuous period of time due to medical condition including any time for treatment and recovery? No☐ Yes☐

If so, estimate beginning_____and ending_____ dates for incapacity period.

During this time, will the patient need care from the employee? No☐ Yes☐

4) Will the patient require follow-up treatment appointments, an intermittent schedule, or reduced schedule because of the medical condition? No☐ Yes☐

During this time, will the patient need care from the employee? No☐ Yes☐

If so, estimate treatment schedule and time required for each appointment including recovery period.

_____

_____

- Treatment schedule: _____times per week _____times per month

  _____Hours needed for each appointment

  Start date_____ End date _____

- Reduced work schedule: _____Number of hours employee can work per day

  Start date_____ End date _____

5) Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? No☐ Yes☐

   Does the patient need care during these flare-ups? No☐ Yes☐ If yes,

   Frequency _____Times per week _____Times per month

   Duration _____Hours per episode _____Days per episode

   Start date_____ End date_____

6) Describe other relevant medical facts, if any, related to this condition (symptoms, diagnosis, or regimen of continuing treatment, specialized equipment): _____

   _____

   _____

Provider's name: _____

Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

_____ _____
Signature of Health Care Provider Date