Form A--Application for Extended Leave

Extended leaves are those expected to last <u>more</u> than 10 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 request **<u>will not</u>** be **<u>accepted</u>** until all required documents are complete. You will be notified of your leave status by mail and to your APS email.

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

Type of Leave	Required Documentation
☐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, as applicable: sick leave, personal leave, 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. Leave balances will cease to accrue once an employee is in an unpaid status.

For **Illness in the Immediate Family Leave**, as applicable, the district will exhaust your accrued sick leave accrual, personal leave, and annual. After these accruals are exhausted, the remainder of your leave will be unpaid.

Sign this form**.** Submit all completed/signed forms and supporting documentation to Extended Leaves Office via email to Extended.Leaves@aps.edu OR by fax to 505-884-0536. In person visits are limited; please avoid in person visits to the greatest extent possible.

______________________________ ______________

Signature Date

updated 11-19-2021

FORM E- EMPLOYEE

Certification of Health Care Provider for
Employee's Serious Health Condition

Employee/Patient Name: ____

Employee/Patient Address: ____

Employee ID Number: ______________ Employee's Job Title: __________________________

Instructions for the Health Care Provider: Your patient has requested a leave of absence. 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 employee for this condition: ______________________________

____

2) What, if any, job function is the employee unable to perform? ____________________

____

3) Is the medical condition a pregnancy? No☐ Yes☐ Expected delivery date______________

4) Will the employee be incapacitated for a single continuous period of time due to his/her medical condition including any time for treatment and recovery? No☐ Yes☐

   If so, estimate beginning_____________and ending_____________ dates for incapacity period.

5) Will the employee need to attend follow-up treatment appointments, work part-time, or be on a reduced work schedule because of the medical condition? No☐ Yes☐

   If so, include dates of appointments and time required for each appointment including recovery period.

____

____

____

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- Treatment schedule: __________times per week ______times per month

  ______Hours needed for each appointment

  Start Date______________ End Date______________

- Part-time work schedule: _______hours per day ______days per week

  Start Date______________ End Date______________

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

  Start Date______________ End Date______________

6) Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No☐ Yes☐ If yes,

   Frequency ___________Times per week ___________Times per month

   Duration ___________Hours per episode ___________Days per episode

   Start Date____________________ End Date_________________________

7) 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