Form A--Application for Extended Leave

Extended leaves are those expected to last more 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 **will not** be **accepted** 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

☐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

A-SCHEDULE EMPLOYEES ONLY - (teachers, counselors, nurses, social workers, etc. – see the APS/ATF Negotiated Agreement for the full list of covered employees)

FORM P - 40% PAID PARENTAL LEAVE BENEFIT

Supplemental Form for A-Schedule Employees ONLY
THIS FORM MUST ACCOMPANY *FORM A - APPLICATION FOR EXTENDED LEAVE*

PRINT LEGIBLY

DATE: _____ **CELL PHONE:** _____

NAME: _____ **EMPLOYEE ID:** _____

I acknowledge that:

1) once my leave is processed according to my specifications submitted on *Form A* and *Form P*, the details for this paid benefit will not be revised, AND
2) failure to submit this completed *Form P* with my *Form A* will result in **DENIAL** to receive the 40% APS-paid parental leave benefit.

SIGNATURE (written or electronic): _____

40% APS-paid parental leave benefit: 30 work days of 40% daily pay, paid by APS (this paid benefit is in addition to any parental leave you may take from your own accrued leave balances); *REMINDER – if received, this APS-paid benefit is additional compensation (beyond your APS employment contract) to be reported as such on your W-2 form for tax reporting purposes*.

To process your request, please respond to the following:

- Do you want to receive this paid parental leave benefit?
  ☐ Yes – if yes, complete items A, B, C and D below.
  ☐ No – if no, skip to item D.

A. **WHEN** do you want to receive the 30 work days of the 40% APS-paid benefit? (parental leave dates are specified on *Form A – Application for Extended Leave*)
   ☐ START – first 30 work days of my paid parental leave
   ☐ END – last 30 work days of my paid parental leave (immediately prior to unpaid leave status)

B. **HOW** do you want to receive the 40% APS-paid benefit?
   ☐ supplement with 60% daily from my own accrued leave = 100% daily pay through the 30 work days of the paid benefit (if you have sufficient accrued leave to cover it)
   ☐ do NOT supplement from my own accrued leave = ONLY 40% daily pay through the 30 work days of the paid benefit (this means you will be 60% UNPAID daily through the 30 work days of leave)

C. ☐ **ACKNOWLEDGE**: your scheduled payroll deductions and any required payroll withholdings will continue through the paid benefit period, whether at 40% daily pay or supplemented for 100% daily pay (contact your Payroll Specialist with questions, https://www.aps.edu/finance/payroll/payroll-specialist-assignments)

D. ☐ **SUBMIT**: send this completed form with your *Form A – Application for Extended* Leave and *Physician/Medical Provider Form* to Extended.Leaves@aps.edu.

ALBUQUERQUE PUBLIC SCHOOLS

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.

   _____

   _____

   _____

- 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