

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

<input type="checkbox"/> Advance Study Leave (Unpaid)	Form A and letter of acceptance, class schedule, and grades for prior semester, (if applicable)
<input type="checkbox"/> 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
<input type="checkbox"/> Domestic Violence Leave	Form A and legal documentation
<input type="checkbox"/> Illness in the Immediate Family	Form A and Family-Certification of Health Care Provider
<input type="checkbox"/> Injury or Illness of Military Member	Form A and WH385
<input type="checkbox"/> Intermittent Leave	Form A and Employee or Family-Certification of Health Care Provider
<input type="checkbox"/> Medical Leave	Form A and Employee-Certification of Health Care Provider
<input type="checkbox"/> Military Service Leave	Form A and military orders or commander's letter
<input type="checkbox"/> Parental Leave (Birth of a child)	Form A and Employee-Certification of Health Care Provider
<input type="checkbox"/> 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)
<input type="checkbox"/> Part-time Leave	Form A and Statement Page (A Schedule Only--no supervisor signature required)
<input type="checkbox"/> Personal Leave (Unpaid)	Form A and Statement Page signed by supervisor (A, B, G/H Schedule employees do not need supervisor signature)
<input type="checkbox"/> Political	Form A and confirmation of appointment
<input type="checkbox"/> Qualifying Exigency	Form A and Form WH 384
<input type="checkbox"/> 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



EMPLOYEE

Certification of Health Care Provider for
Employee's Serious Health Condition
Page 1

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