

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) <input type="checkbox"/> Assault Leave <input type="checkbox"/> Domestic Violence Leave <input type="checkbox"/> Illness in the Immediate Family <input type="checkbox"/> Injury or Illness of Military Member <input type="checkbox"/> Intermittent Leave <input type="checkbox"/> Medical Leave <input type="checkbox"/> Military Service Leave <input type="checkbox"/> Parental Leave (Birth of a child) <input type="checkbox"/> Parental Leave (Non-Birth Only) <input type="checkbox"/> Part-time Leave <input type="checkbox"/> Personal Leave (Unpaid) <input type="checkbox"/> Political <input type="checkbox"/> Qualifying Exigency <input type="checkbox"/> Union Leave	Form A and letter of acceptance, class schedule, and grades for prior semester, (if applicable) Form A and police report, and health care provider certification, employees also complete First Report of Injury and contact Risk Management at 830-8466 Form A and legal documentation Form A and Family-Certification of Health Care Provider (can only use 3 days of sick leave) Form A and WH385 Form A and Employee or Family-Certification of Health Care Provider Form A and Employee-Certification of Health Care Provider Form A and military orders or commander's letter Form A and Employee-Certification of Health Care Provider 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) Form A and Statement Page (A Schedule Only--no supervisor signature required) Form A and Statement Page signed by supervisor (A, B, G/H Schedule employees do not need supervisor signature) Form A and confirmation of appointment Form A and Form WH 384 Form A and name of Union you will represent _____
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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 *to the extent that is allowed under district leave policies (3 or 5 days only), 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 889-4886 (A-L) or 889-4865 (M-Z).

Signature

Date



FAMILY MEMBER

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

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