LOS ANGELES UNIFIED SCHOOL DISTRICT
PERSONNEL COMMISSION
WORKFORCE MANAGEMENT, CLASSIFIED EMPLOYMENT SERVICES BRANCH

LEAVE OF ABSENCE PACKET FOR CLASSIFIED EMPLOYEES

These forms must be completed for absences more than 20 consecutive work days

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This leave of absence packet contains the following items:

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GENERAL INFORMATION

Refer to the appropriate collective bargaining agreement for information on leaves, which can be found at http://personnel.lausd.net. Click on "Collective Bargaining Unit Agreements" under "Quick Links." The agreements specify the types of leaves available, the maximum length of each leave, and the employee's responsibility for notifying the work location and the Classified Employment Services Branch. Failure to comply with these notification requirements and/or failure to return on time may be considered resignation from service.

Refer to Personnel Commission Rules for similar provisions if you are exempt from collective bargaining representation.

INSTRUCTIONS

Fill in the required information and indicate the type of leave requested. Your work location must verify the first day of absence. This request is to be sent to the Workforce Management, Classified Employment Services Branch, P.O. Box 513307, Los Angeles, CA 90051-1307. **You are responsible for notifying your work location of your absence.** In order to be paid for illness or industrial illness/injury leave, you must notify your time reporter and submit the appropriate documents to your location. If you have questions regarding the continuation of your medical, dental, or life insurance, contact the Benefits Administration Department at (213) 241-4262. The Leave of Absence Request for Classified Employees form and supporting documents (if applicable) must be submitted for all leaves over 20 consecutive work days in addition to any workers' compensation paper work. The Workforce Management, Classified Employment Services Branch requires original documents to verify leaves. Your location should retain a copy of the document for your files. For Laws and Rules on Leaves of Absences, refer to Personnel Commission Rule 803, which can be obtained by visiting the Personnel Commission home page at http://personnel.lausd.net. Please note that the Attending Physician/Health Care Provider Statement, included in this packet, is a separate form, and needs to be completed in addition to the FMLA Certification of Health Care Provider. The purpose of the Attending Physician/Health Care Provider Statement is for the Classified Employment Services Branch to confirm the need for a formal leave of absence. The FMLA Certification of Health Care Provider is to confirm if qualifying job protections under FMLA/CFRA are applicable. The Attending Physician/Health Care Provider Statement needs to be sent to the Workforce Management, Classified Employment Services Branch, whereas the FMLA Certification of Health Care Provider is to be retained at the site. **Failure to return complete documents will result in the employee not getting paid.**

DEFINITIONS

MANDATORY LEAVES

Mandatory Leaves are approved by the Workforce Management, Classified Employment Services Branch of the Personnel Commission. Applicant must complete and submit all appropriate documentation.

1. **ILLNESS (SELF) LEAVE:** Is a disabling condition which prevents the performance of job duties and/or causes the inability to perform normal daily functions. An attending physician/health care provider statement must be completed. In the case of a FMLA-related illness leave, refer to work location for FMLA guidelines. For general questions regarding FMLA, contact the FMLA Leaves Section of the Division of Risk Management at (213) 241-3954.
2. **& 3. INDUSTRIAL ILLNESS/INJURY LEAVE:** Up to 60 days of your illness balance may be restored upon approval from Workers' Compensation. For further information, refer to your collective bargaining agreement. If you have questions regarding industrial injury leaves or workers' compensation, contact the Office of Risk Management at (213) 241-3138. An attending

physician/health care provider statement must be completed. If applicable, refer to work location for FMLA guidelines. For general questions regarding FMLA, contact the FMLA Leaves Section of the Division of Risk Management at (213) 241-3954.

4. **ACT OF VIOLENCE LEAVE:** An attending physician/health care provider statement must be completed. If you have questions regarding Act of Violence leaves, contact the Office of Risk Management at (213) 241-3138. If applicable, refer to work location for FMLA guidelines. For general questions regarding FMLA, contact the FMLA Leaves Section of the Division of Risk Management at (213) 241-3954.
5. **PREGNANCY-RELATED DISABILITY LEAVE:** Is a temporary disability due to miscarriage, pregnancy or childbirth. An attending physician/health care provider statement must be completed. If applicable, refer to work location for FMLA guidelines. For general questions regarding FMLA, contact the FMLA Leaves Section of the Division of Risk Management at (213) 241-3954.
6. **ILLNESS (FAMILY) LEAVE:** Normally an unpaid leave that may not exceed 12 weeks per FMLA year. Illness Family Leave is available only to employees who submit proper documentation and are eligible for FMLA protection (see your bargaining unit agreement). An attending physician/health care provider statement must be completed. If applicable, refer to work location for FMLA guidelines. For general questions regarding FMLA, contact the FMLA Leaves Section of the Division of Risk Management at (213) 241-3954.
7. **BONDING LEAVE FOR BIRTH/ADOPTION/FOSTER CARE FOR NEW CHILD:** To be taken within the first year following the date of birth or date of placement for adoption or foster care. If applicable, refer to work location for FMLA/CFRA guidelines. For general questions regarding FMLA, contact the FMLA Leaves Section of the Division of Risk Management at (213) 241-3954.
8. **MILITARY LEAVE:** You cannot be required to resign because of absence in response to military orders. To be eligible for paid leave, you must have at least one year of District service (you may count any prior military leave as part of that year). The employee shall be required to submit appropriate official military orders to the Personnel Commission for any orders that require the employee be absent more than 20 consecutive working days. (Leave paperwork is not needed for absences of 20 days or less.)
9. **MILITARY CAREGIVER LEAVE:** Normally an unpaid leave that may not exceed 26 weeks per FMLA year. Military Caregiver Family Leave is available only to employees who are eligible for FMLA protection and submit proper documentation to care for a covered servicemember with a serious illness or injury incurred in the line of duty on active duty. This provision also extends FMLA protection to additional family members (i.e., next of kin) beyond those who may take FMLA leave for other qualifying reasons. An attending physician/health care provider statement from a specific military health care provider must be completed or you may submit "invitational travel orders" (ITOs) or "invitational travel authorizations" (ITAs) issued by the DOD. For general questions regarding FMLA, contact the FMLA Leaves Section of the Division of Risk Management at (213) 241-3954.
10. **QUALIFYING MILITARY EXIGENCY LEAVE:** Normally an unpaid leave that may not exceed 12 weeks per FMLA year. Qualifying Military Exigency Family Leave is available only to employees who are eligible for FMLA protection and submit proper documentation for a covered military member serving in the National Guard or Reserves to use for any qualifying exigency arising out of the fact that a covered military member is on active duty or called to active duty status in support of a contingency operation. Qualifying Exigency includes: (1) short-notice deployment of a week or less; (2) military events and related activities; (3) urgent (as opposed to recurring and routine) childcare and school activities; (4) financial and legal tasks to deal with a family member's active duty; (5) counseling; (6) spending time with the covered servicemember on rest and recuperation breaks during deployment; (7) post-deployment activities. The employee shall be required to submit appropriate official military orders of the covered family member. For general questions regarding FMLA, contact the FMLA Leaves Section of the Division of Risk Management at (213) 241-3954.
11. **CHARTER LEAVE:** Available for Board of Education-approved independent start-up or conversion charter schools. For further information, refer to your collective bargaining agreement.
12. **ORGANIZATION (UNION) LEAVE:** If a member takes an authorized leave of absence to serve as an elected official of a labor organization.
13. **PROFESSIONAL GROWTH STUDY LEAVE: (Available for Bargaining Unit B, D and S members.)** To be taken to pursue a program of study in residence at an institution of higher learning when such program is designed to improve the employee's professional services to the District. For further information, refer to your collective bargaining agreement.
14. **OTHER LEAVE:** To be indicated for reasons not mentioned above.

PERMISSIVE LEAVES

Permissive Leaves are granted at the discretion of both your location and your division head or local district superintendent. All permissive leaves must be approved prior to the beginning date of the leave. Your supervisor or the Classified Employment Services Branch will notify you if your leave is disapproved or if it has been determined that you are not eligible for the leave requested.

15. **CARE OF OWN CHILD LEAVE:** Can be requested for up to the child's third birthday (Non-FMLA). Care of own child leave may not be granted beyond the child's third birthday. Child's date of birth must be stated on the form and proof of the child's date of birth may be required.
16. **PERSONAL/OTHER LEAVE:** To be indicated for personal reasons not mentioned above. Personal reasons include family matters, community service and education or training. Please discuss the reason with your supervisor. For requests for personal leaves related to the care of a child or seriously ill family member, please see number 6- "Illness (Family) Leave" above.

LOS ANGELES UNIFIED SCHOOL DISTRICT
PERSONNEL COMMISSION
WORKFORCE MANAGEMENT, CLASSIFIED EMPLOYMENT SERVICES BRANCH

LEAVE OF ABSENCE REQUEST FOR CLASSIFIED EMPLOYEES
(FOR MANDATORY LEAVES ONLY)

This form must be completed for absences more than 20 consecutive work days

TO BE COMPLETED BY EMPLOYEE

Last Name | First Name | MI | Person ID/Employee Number

Address while on leave: Number & Street | City & State | Zip Code | ( ) - Contact number while on leave

Job Title & Job/Class Code | Work Location | ( ) - Work number

I request: ☐ A leave of absence from: ___/___/___ to: ___/___/___, inclusive.
☐ An extension of my leave from: ___/___/___ to: ___/___/___, inclusive.

For the following reason (check one):

MANDATORY LEAVES (mandatory under all applicable circumstances and with appropriate verification):

☐ 1. Illness (Self) Leave
☐ 2. Industrial Illness/Injury Leave- Original injury date: ___/___/___
☐ 3. Industrial Illness/Injury Leave (FOR SCHOOL POLICE ONLY) - Original injury date: ___/___/___
☐ 4. Act of Violence Leave - Original injury date: ___/___/___
☐ 5. Pregnancy-related Disability Leave - Expected delivery date: ___/___/___
☐ 6. Illness (Family) Leave- Relationship:
☐ 7. Bonding Leave for birth/adoption/foster care for new child - Date into home: ___/___/___
☐ 8. Military Leave. ATTACH OFFICIAL ORDERS (for absences of more than 20 days)
☐ 9. Military Caregiver FMLA Leave - Relationship:
☐ 10. Military Exigency FMLA Leave. ATTACH OFFICIAL ORDERS OF FAMILY MEMBER
☐ 11. Charter Leave. Name of Charter School:
☐ 12. Organization (Union) Leave
☐ 13. Professional Growth Study Leave (For Bargaining Units B, D and S)
☐ 14. Other (ex. Peace Core, Red Cross, Merchant Marine, etc.)

Refer to work location for FMLA guidelines for items 1-7, 9 & 10. For general questions regarding FMLA, contact the FMLA Leaves Section, Division of Risk Management at (213) 241-3954.

I CERTIFY that I was not and will not be employed elsewhere during the period covered by this request for illness or industrial illness/injury leave. I also certify that I have read and understand the information on this form. Furthermore, I certify that my absence is because of the indicated reason and that all of the information on this form is true and correct. If I am filing a claim for workers' compensation, I also certify that I will report to the workers' compensation claims administrator any money that I earn from any other employer during the time period claimed by this certification. If I do not report any information regarding other earnings, I acknowledge that I may be in violation of the law, and the penalty may be a fine, loss of benefits, and/or imprisonment.

If I do not return to my job within 5 days after the expiration of an unpaid leave or an approved extension of an unpaid leave, please consider this my resignation from the Los Angeles Unified School District. I declare under penalty of perjury that all of the foregoing is true and correct.

Employee's Signature: _____ Date: _____

PROCEED TO NEXT PAGE →

TO BE COMPLETED BY LOCATION

1ST DAY ABSENT: _____ (*REQUIRED*)

ACKNOWLEDGEMENT OF MANDATORY LEAVE REQUEST: Because leaves 1-14 are mandatory, the administrator's signature signifies only an acknowledgement of the leave.

Administrator Name (Print): _____ Signature: _____ Date: _____

For Classified Employment Services Branch Use Only: ☐ Approved ☐ Disapproved

Approved by: Signature: _____ **Date:** _____

LOS ANGELES UNIFIED SCHOOL DISTRICT
PERSONNEL COMMISSION
WORKFORCE MANAGEMENT, CLASSIFIED EMPLOYMENT SERVICES BRANCH

LEAVE OF ABSENCE REQUEST FOR CLASSIFIED EMPLOYEES

ATTENDING PHYSICIAN/HEALTH CARE PROVIDER STATEMENT

(Must Be Completed for Mandatory Leaves 1-6 & 9)

EMPLOYEE: COMPLETE THE FOLLOWING (PLEASE PRINT)

Last Name	First Name	MI	Person ID/Employee Number

Job Title & Job/Class Code	Work Location

RELEASE OF MEDICAL INFORMATION

I hereby authorize any Physician/Health Care Provider who has provided medical care regarding any condition related to the current leave request to release any or all pertinent information and records to the Los Angeles Unified School District.

Employee Signature	Date	Family Member's Signature, if applicable

Submit original documents to:
Los Angeles Unified School District
Workforce Management, Classified Employment Services Branch
P.O. Box 513307
Los Angeles, CA 90051-1307

PHYSICIAN/HEALTH CARE PROVIDER: COMPLETE THE FOLLOWING (PLEASE PRINT)

☐ ILLNESS

☐ INDUSTRIAL INJURY

☐ PREGNANCY-RELATED DISABILITY

☐ FAMILY MEMBER ILLNESS

Patient's Name: _____ Relationship: _____

Is this a Permanent Disability? Yes: ☐ No: ☐

Date incapacity began: _____

In my opinion, this employee will be medically able to return to work, effective: _____

In my opinion, this family member will no longer require assistance from employee effective: _____

I certify that I am the treating Physician/Health Care Provider for the above-named individual, who is under my professional care, and that the information is true and correct to the best of my knowledge.

Original Signature of Physician/Health Care Provider	Date

Name of Physician/Health Care Provider (Type or Print)	State License No

Business or Clinic Name	(____) _____ Telephone Number

Address Number & Street	City & State	Zip

LOS ANGELES UNIFIED SCHOOL DISTRICT
PERSONNEL COMMISSION
WORKFORCE MANAGEMENT, CLASSIFIED EMPLOYMENT SERVICES BRANCH

LEAVE OF ABSENCE REQUEST FOR CLASSIFIED EMPLOYEES
(FOR PERMISSIVE LEAVES ONLY)

This form must be completed for absences more than 20 consecutive work days

TO BE COMPLETED BY EMPLOYEE

Last Name | First Name | MI | Person ID/Employee Number

Address while on leave: Number & Street | City & State | Zip Code | ( ) - Contact number while on leave

Job Title & Job/Class Code | Work Location | ( ) - Work number

I request: ☐ A leave of absence from: ___/___/____ to: ___/___/____, inclusive.
☐ An extension of my leave from: ___/___/____ to: ___/___/____, inclusive.

For the following reason (check one):

PERMISSIVE LEAVES

☐ 13. Care of own child, up to third birthday only (non FMLA). Child's birth date: ___/___/___

☐ 14. Personal/Other Leave. Reason:

I CERTIFY that I have read and understand the information on this form. Furthermore, I certify that my absence is because of the indicated reason and that all of the information on this form is true and correct.
If I do not return to my job within 5 days after the expiration of an unpaid leave or an approved extension of an unpaid leave, please consider this my resignation from the Los Angeles Unified School District. I declare under penalty of perjury that all of the foregoing is true and correct.

Employee's Signature: _____ Date: _____

TO BE COMPLETED BY LOCATION

1ST DAY ABSENT: _____ (*REQUIRED*)

APPROVAL OF PERMISSIVE LEAVE REQUEST: If a permissive leave is granted, the position must be held available until the employee returns. Leaves 13-14 must have the approval of Principal/Administrator **and** Division Head/Local District Superintendent. If the request for leave is denied, return form to the employee.

Principal/Administrator: ☐ Approved ☐ Disapproved

Signature _____ Print Name: _____ Date: _____

Division Head/ Local District Superintendent: ☐ Approved ☐ Disapproved

Signature _____ Print Name: _____ Date: _____

For Classified Employment Services Branch Use Only: ☐ Approved ☐ Disapproved

Approved by: Signature: _____ **Date:** _____

LOS ANGELES UNIFIED SCHOOL DISTRICT
PERSONNEL COMMISSION
WORKFORCE MANAGEMENT, CLASSIFIED EMPLOYMENT SERVICES BRANCH

LEAVE OF ABSENCE REQUEST FOR CLASSIFIED EMPLOYEES

NOTICE OF INTENT TO RETURN TO WORK

INSTRUCTIONS FOR EMPLOYEES AND WORK LOCATIONS

The Notice of Intent to Return to Work form should be completed by all employees returning from a formal leave of absence. The Physician/Health Care Provider's portion of the form is completed only for those returning from an illness, injury or pregnancy-related disability leave. Prior to returning to work, the employee must notify his/her location as soon as possible but no less than 24 hours prior to his/her return date. This form may also be used for early return to work.

The employee must present a copy of this form to the Workforce Management, Classified Employment Services Branch and a copy of this form to his/her supervisor. **If the physician indicates any restrictions, the employee must contact the Reasonable Accommodations Unit as soon as possible at (213) 241-1319.**

TO BE COMPLETED BY EMPLOYEE: (FOR MANDATORY AND PERMISSIVE LEAVES)

Last Name	First Name	MI	Person ID/Employee Number

Address: Number & Street / City & State / Zip Code	Telephone number
	( ) -

Job Title & Job/Class Code	Return Date

Name of Work Location

_____ _____
Employee Signature Date

TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER FOR ILLNESS, INJURY OR PREGNANCY-RELATED DISABILITY LEAVES: (FOR MANDATORY LEAVES ONLY)

_____
Approved Return to Work Date

_____ _____
Last Name First Name Middle Initial State License Number

_____
Address: Number & Street City & State Zip Code

_____ _____
Physician/Health Care Provider's Signature Date

TO BE COMPLETED BY LOCATION:

1ST DAY BACK TO WORK: _____ (*REQUIRED*)

Print Name: _____ Title: _____Date: _____

Signature: _____