LA JOYA INDEPENDENT SCHOOL DISTRICT
TEMPORARY DISABILITY
EMPLOYEE REQUEST FOR LEAVE FORM

1. **Name**(First Name, Middle Initial, Last Name)	2. **Employee's Position**
SS#	**Campus/Location:**

3. Reason for leave request: (Please Check (√) one)

____a. Because of employee's own serious health condition that makes him/her unable to perform job function.

____b. Pregnancy or pregnancy-related conditions.

Employees seeking leave must provide medical certification as form of documentation attached to this request form. Please provide a brief explanation. (You may attach additional documentation as necessary.)

4. Date on which you wish to **begin** leave.	5. Date of **anticipated return** to work.

DEC (LEGAL) Temporary Disability: Each full-time certified educator shall be given a leave of absence for temporary disability at any time the educator's condition interferes with the performance of regular duties. The contract or employment of the educator may not be terminated while the educator is on a leave of absence for temporary disability. For purposes of temporary disability leave, pregnancy is considered a temporary disability. [page 2 of 13]

6. **NOTICE:** ***Read each statement. Place a check (√) mark in each space provided.***

___I understand that Temporary Disability Leave runs concurrently with: FMLA, W.C., State Personal/Sick, Local Leave.

___I understand that the total amount of days allowable for all leaves is **180 calendar days**.

___I hereby agree that while I am on temporary disability leave, I will be responsible for the entire Medical Insurance Premium. **[Employee + District's contribution]**

___I understand that I will provide a " Fitness for Duty" medical certificate upon return to work.

Signature:_____**Date**:_____

7. Superintendent's Response - Approved Leave Request: **[ ] YES* [ ] NO**

***Leave is Approved** **FROM:**_____**(DATE)**

TO:_____**(Expiration Date)**

Superintendent's Signature:_____***Date:***_____

White: Personnel File Yellow: Payroll Pink: Campus/Department