



**Niagara Falls City School District  
Office of Human Resources**

630-66<sup>th</sup> Street, Niagara Falls, NY 14304

(716) 286-4225 (Phone) ♦ (716) 286-4224 (Fax)

**Staff Leave/Medical Request**

Employee: \_\_\_\_\_

Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Position: \_\_\_\_\_

Location: \_\_\_\_\_

**Please check reason for Leave**

	<b><u>Type of Leave (Select one:)</u></b>	<b><u>From</u></b>	<b><u>Through</u></b>
<input type="checkbox"/>	<b>Medical (Must provide medical certification)</b> 1. Own serious health condition (not work related) 2. Maternity: Care for newborn/placed child  <b>Benefits continue while using sick days/sick bank</b>		
<input type="checkbox"/>	<b>FMLA (Unpaid Leave). Must provide medical certification:</b> 1. Own serious health condition (not work related) 2. Maternity: Care for newborn/placed child 3. Care for parent/spouse/child w/serious health condition  <b>Benefits continue only for 12 weeks of approved FMLA (60 days)</b>		
<input type="checkbox"/>	<b>Personal (Unpaid Leave).</b> Must provide letter giving brief description of reason for leave.  <b>Not entitled to Benefits</b>		
<input type="checkbox"/>	<b>Educational (Unpaid Leave).</b> Must provide brief description of need for leave and documentation to support enrollment in a college program.  <b>Not entitled to Benefits</b>		
<input type="checkbox"/>	<b>Military leave (Unpaid Leave) Must attach orders.</b>  <b>Benefits continue only for 12 weeks of approved FMLA (60 days)</b>		
<input type="checkbox"/>	<b>Other: Leave to take other position in District</b>		

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A leave of absence may consist of leave without pay and/or paid leave (i.e. vacation, personal illness, etc.) Paid leave may be used in accordance with applicable policy/contracts.

Anticipated Date for Maternity Leave	_____				
Pregnancy Leave	_____	6 Weeks	OR	_____	8 Weeks
Child Rearing (FMLA, Unpaid Leave)	_____	12 Weeks	OR	_____	One (1) Semester

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Designation of Leave

To be completed by HRO Department:

\_\_\_\_\_ Your leave is denied for the following reason(s) \_\_\_\_\_

\_\_\_\_\_ Your leave has been approved

Date Employee Notice of Approval Sent \_\_\_\_\_

Date FMLA Notice sent out: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Administrator for Human Resources