

GENERAL LEAVE REQUEST FORM

NAME OF EMPLOYEE: _____

ADDRESS: _____

SOCIAL SECURITY #: _____ PHONE: _____

SCHOOL: _____ POSITION: _____

IF TEACHER, GRADE AND/OR SUBJECT: _____

REASON FOR LEAVE: _____

LAST DAY THAT YOU WILL WORK: _____

NUMBER OF SICK/VACATION DAYS YOU WISH TO USE: _____

EFFECTIVE DATE OF LEAVE: _____
(TO BE FILLED OUT BY CENTRAL OFFICE)

DATE YOU WILL RETURN TO WORK: _____

SIGNATURE OF EMPLOYEE: _____

DATE REQUESTED: _____

Signature of Director of Human Resources: _____

Date Reviewed: _____

SPECIAL NOTE: In keeping with the Board's policy that employees going on leave without pay will be held responsible for their own insurance, you are requested to:

1. Make arrangements with the payroll department to pay your premium.
2. Cancel in writing to the payroll department.
 - a) Should you cancel, it will be necessary for hospitalization coverage by proving your insurability upon returning to work.

Arrangements must be made before your leave becomes effective, or your insurance will automatically be cancelled. Release forms with proper physician's statement (if medical) must be obtained from Human Resources Office prior to returning to work.

EMPLOYEES ON LEAVE WITHOUT PAY

CHECK ONE AND SIGN

_____ I WISH TO KEEP MY GROUP HOSPITALIZATION COVERAGE WITH THE IBERIA PARISH SCHOOL BOARD WHILE I AM ON LEAVE WITHOUT PAY. (ATTACHED IS MY MONTHLY PREMIUM.)

Employee's Signature

_____ I WISH TO CANCEL MY GROUP HOSPITALIZATION COVERAGE WITH THE IBERIA PARISH SCHOOL BOARD WHILE I AM ON LEAVE WITHOUT PAY. I FULLY UNDERSTAND THAT WHEN I RETURN TO WORK, I WILL HAVE TO REAPPLY FOR HOSPITALIZATION COVERAGE AND MAY BE SUBJECT TO THE 24 MONTH PRE-EXISTING CONDITION CLAUSE IN OUR POLICY.

Employee's Signature