

GARFIELD BOARD OF EDUCATION
LEAVE OF ABSENCE REQUEST

MATERNITY LEAVE

Name _____
Date _____
School _____ Position _____

Requested Dates: From _____ To _____
Total No. of Days Absent _____
* **Total No. of Sick Days** _____
(If available at time of birth)
Total No. of Unpaid Days _____
Dr. Note (Attached) : _____

* Use of Allowable Sick days – 40 days)

PLEASE ADVISE THE SUPERINTENDENT'S OFFICE IF
THERE IS ANY CHANGE IN THE ABOVE DATES (Ext. 2300)

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ADOPTION

Official Documents Attached _____
Requested Dates: From _____ To _____
Total No. of Days Absent _____
Total No. of Sick Days _____
Allowable use of Sick Days (20) If Available
Total No. of Unpaid Days _____

PLEASE ADVISE THE SUPERINTENDENT'S OFFICE IF
THERE IS ANY CHANGE IN THE ABOVE DATES (Ext. 2300)

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APPROVED: _____
Superintendent of Schools
DATE: _____

Board of Education Resolution No. _____

NOTE: Be sure to send in "Return from Leave of Absence Form" when you return to school - attach Doctor's note to return to school

cc: Building Principal
Staff Member
Payroll Department – Business Office