

**PLEASANTVILLE PUBLIC SCHOOLS**  
900 W. LEEDS AVENUE  
P.O. BOX 960  
PLEASANTVILLE NJ 08232

**FAMILY LEAVE REQUEST**

NAME \_\_\_\_\_ SCHOOL \_\_\_\_\_

POSITION \_\_\_\_\_ PRINCIPAL \_\_\_\_\_

Are you tenured in your position: \_\_\_\_\_ Yes \_\_\_\_\_ No

Original date of hire in district: \_\_\_\_\_

Have you worked the number of qualifying hours in the previous year? \_\_\_\_\_ Yes \_\_\_\_\_ No

DATES OF REQUESTED LEAVE

Date of last work day: \_\_\_\_\_

Date of start of leave (without pay): \_\_\_\_\_

Is leave to be taken under: \_\_\_\_\_ Federal Medical Leave Act  
\_\_\_\_\_ New Jersey Family Leave

Amount of leave requested: \_\_\_\_\_ weeks (not exceed 12 weeks)

\_\_\_\_\_ consecutive \_\_\_\_\_ intermittent(\*) \_\_\_\_\_ reduced(\*)  
*\*Intermittent or reduced leave must be approved by your employer.*

Is this your own illness or that of a family member? \_\_\_\_\_

If for a "family member," please complete the following:

Qualified family member (name): \_\_\_\_\_

Relationship: \_\_\_\_\_

Anticipated date of return: \_\_\_\_\_

Has your Principal/Supervisor been made aware of your request? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Date Employee's Signature Date Principal/Supervisor's Signature

Office Use Only

NAME OF SUBSTITUTE TEACHER: \_\_\_\_\_

NUMBER OF DAYS WITH PAY (SICK LEAVE) \_\_\_\_\_ Days  Mail check  Will pick up

NUMBER OF DAYS WITHOUT PAY \_\_\_\_\_ weeks

**PLEASE FORWARD TO THE DIRECTOR, HUMAN RESOURCES**