Human Resource Services

Request for Disability Leave of Absence

Certificated Employees

Name:	Social Security Number:
Street Address:	City/State/Zip:
Home Phone:	Work Phone:
Position Title:	Hire Date in District (mm/dd/yy):
Date Leave Begins (mm/dd/yy):	Date Leave Ends (mm/dd/yy):
School/Department:	Subject/Grade Level (if applicable):

Reason for Leave: (Please refer to your union contract.)

The request for this leave of absence is made in accordance with the provisions of the California State Education Code (Section 44986), which provide that any regular employee of the District may, at the discretion of the Board, be granted leave of absence for reasons of disability without pay.

I understand that a disability leave of absence shall continue only for the term of the eligible disability, and in no case shall it exceed thirty-nine (39) months (Education Code 44986). I further understand that the leave will be granted only upon notification from the State Teachers Retirement System to the District that the employee has been accepted for a disability allowance by the State Teachers Retirement System and with the approval of the Superintendent.

I also understand that the district agrees to pay the medical insurance premiums for employees who have served ten consecutive years of service in the District immediately prior to the beginning of the disability leave of absence. A Board-approved leave of absence shall not constitute a break in service for the purpose of determining eligibility for this benefit.

I further understand that upon reaching age sixty (60), the disability leave of absence will be converted to service retirement unless otherwise notified by the State Teachers Retirement System.

I further understand that I am to give written notice of my intention to return from this leave not less than thirty (30) days before the expiration date of the leave, and that I am to furnish with this notice a written statement from a physician to the effect that I am physically able to resume my duties on a full-time basis.

➲ My address while on leave will be: _____

If the above request is granted, I understand that I will:

1. Contact the Benefits Office regarding benefits and insurance coverage (if any) during my leave of absence.
2. Comply with the requirements and conditions set forth in the union contract for the bargaining unit to which I belong.
3. Request any needed extension of leave in writing.
4. Give written notice no less than thirty (30) days before the expiration date of my leave regarding whether or not I intend to return.

Employee Signature:	Date:

For Human Resource Services Use Only

Disability allowance verified with STRS by: Date:

Ten consecutive years of service in district immediately prior to leave date: ☐ Yes ☐ No

Hold Position: Transfer to Unassigned:

Recommendation for leave approved by: Date:

Leave of absence granted in accordance with the above agreement:

Signature: Director, Human Resource Services Date

Agenda Date: T.A.P. No.

cc: Principal or Supervisor, Employee, Personnel File

Reference: Education Codes 22126 and 44986