

Arlington Central School District - Office of Human Resources

INTENT TO TAKE LEAVE FORM - ATA

CONGRATULATIONS ON YOUR EXPECTED NEW ARRIVAL!

Teachers may wish to review Article XVII of the ATA contract regarding leaves. The **Medical Disability Form** (attached) should be completed by your doctor three months prior to your expected due date, or earlier if pregnancy complications arise. When you are told to stop working by the doctor, a new doctor's note with effective dates should be submitted to the Office of Human Resources. Even if you are not planning on requesting a leave beyond your childbirth disability period, for sick time purposes we still need this form completed in order to know when your projected disability period will begin. Medical disability begins when instructed by your doctor and the post-partum period is six weeks for a normal delivery and eight weeks for a C-Section.

IMPORTANT: Once you arrive home from the hospital after the baby is born, please call Jeanne Carlos (486-4459)

Paid/Unpaid Disability Leave:

Using your accumulated sick days, this leave starts on the first day you are disabled and will continue through your post-partum period. The post-partum period is six weeks for a normal delivery and eight weeks for a C-section. The Payroll Office (486-4450) can assist you in checking your accumulated sick days.

I am anticipating taking a leave due to maternity disability and childbirth.

Anticipated date of birth _____/_____/_____

Anticipated leave to start _____/_____/_____

Anticipated return date _____/_____/_____

Family Medical Leave (Paid and Unpaid):

If you have worked 1250 hours or more in the last 12 months at Arlington, you may be entitled to 12 weeks of Family Medical Leave. If you wish to request a Family Medical Leave, please complete the attached **Request for Family of Medical Leave**.

I am aware that Family Medical Leave runs concurrently with any of my disability time. For any additional weeks after my paid disability period (up to the twelve (12) FMLA weeks) I understand that I will be covered by the District's health insurance coverage; however, any required employee contributions must be paid by me.

Unpaid Child-Rearing Leave: *(to be completed immediately in order to give the District time to recruit a temporary replacement)*

I am planning to take an unpaid, extended leave for the remainder of the semester or school year. If you want continued District health insurance, you will need to pay the full premium. The Benefits Office (486-4450) can assist you with this. Any accrual of time for purposes of tenure or seniority will be suspended.

I plan to take an unpaid child-rearing leave. I anticipate returning to my position for the start of the _____ semester of the _____/_____ school year.

Anticipated start of leave _____/_____/_____

Anticipated return date _____/_____/_____

Request for leave shall be made at least 90 days prior to the date the requested leave is to begin.

Name _____

Date _____/_____/_____

Address (street, city, state) _____

Home Phone _____

Cell Phone _____

Position _____

Building/Grade/Subject _____

Signature _____

Arlington Central School District

Office of Human Resources

696 Dutchess Turnpike
Poughkeepsie, NY 12603
845-486-4460

MEDICAL DISABILITY FORM*

TO: _____, M.D.

Your patient _____ (*print name*) has indicated to us that he/she will soon be disabled and will be unable to attend usual employment. The employee will be applying for sick time during this period of disability at full pay, and it is necessary for the District to receive a full report on the nature and extent of the disability. Please provide the following information:

1. Nature of disability _____
2. State probable start date of disability _____
3. State probable end date of disability _____
4. **If this is for childbirth**, state expected delivery date _____
5. Check one:
 The disability prevents the employee from performing his/her usual duties
 The employee may perform some duties during the period of disability
please explain _____

6. State the prognosis for recovery _____
7. State the date when the employee may be expected to return to full or partial employment

8. Please state any additional information which may be helpful or pertinent _____

Physician's Name (please print): _____

Business Phone: _____

Address: _____

Physician Signature

Date

PLEASE RETURN TO THE OFFICE OF HUMAN RESOURCES, ARLINGTON CENTRAL SCHOOL DISTRICT
***FMLA LEAVE WILL RUN CONCURRENT WITH ANY DISABILITY.**