APPLICATION FOR LEAVE OF ABSENCE CERTIFICATED SCHOOL-LEVEL EMPLOYEES

DOE OHR 300-001
Last Revised: 01/01/2011
Former DOE Form(s): 400, 400a, 400a.1, 400F

DEPARTMENT OF EDUCATION
Office of Human Resources
Records and Transactions Section, Certificated
P.O. Box 2360 Honolulu, HI 96804

I. EMPLOYEE INFORMATION

Name: _____ Last _____ First _____ M.I. Last 4 digits of SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel#: _____ Position: _____ School/Office: _____

School or Sub-Division Code: _ _ _ Leave Code: _ _ _ Bargaining Unit Code: _ _

II. LEAVE REQUEST (Complete appropriate subsection below.)

☐ Family [1] ☐ Military [4] ☐ Political [5] ☐ Other: _____
☐ Funeral [2] ☐ Personal ☐ Sick [3]
☐ Health, LWOP [3] ☐ Personnel Development ☐ Vacation

[1] Complete and attach Federal Form WH-380F or WH-380E(Sde).
[2] Provide relationship to deceased and address if out of state in #2 below.
[3] Complete Licensed Physician's Statement by completing Section IV at bottom of this form for Health leave or if Sick leave for more than five (5) consecutive days or submit a signed doctor's note verifying current health condition. Approval for sick leave is subject to the availability of accumulated sick leave.
[4] Attach a copy of your military orders with this form (copy) to OHR, Records and Transactions Section, Certificated.
[5] Attach a separate letter justifying political appointment.

I hereby request the following type of leave: ☐ Leave with Pay ☐ Leave without Pay for the calendar period below:

From: _____ (MM/DD/YYYY) To: _____ (MM/DD/YYYY) _____ (# of working days)

1. Is this an extended leave? ☐ Yes ☐ No
2. Provide any additional explanation for leave request (attach a separate sheet if necessary):

_____

Employee Signature: _____ Date: _____ (MM/DD/YYYY)

III. LEAVE APPROVAL

For sick, vacation, and personal leave, Principal/Immediate Supervisor approval required.
For family, military, personnel development, and political leave, **both** Principal/Immediate Supervisor **and** PRO/CAS approval required.

☐ Approved
☐ Not Approved Principal/Immediate Supervisor Signature: _____ Date: _____ (MM/DD/YYYY)

☐ Approved
☐ Not Approved PRO/CAS Signature: _____ Date: _____ (MM/DD/YYYY)

IV. LICENSED PHYSICIAN'S STATEMENT

(To be completed ONLY for HEALTH LEAVE or if SICK LEAVE is for more than five (5) consecutive work days)

I certify that _____ is under my care for health reasons and is not physically able to perform his/her normal work duties from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY).

Licensed Physician Signature: _____ Date: _____ (MM/DD/YYYY)

Name of Licensed Physician (Print): _____ Type of Practice: _____

Address: _____ Tel#: _____

*Distribution: **Leave with Pay (Teachers):** 1. Original - School; 2. Copy 1 - Employee; 3. Copy 2 - PRO (if leave exceeds one month) / **Leave With Pay (EOs):** 1. Original - School; 2. Copy 1 - Employee / **Leave Without Pay and Military Leave With Pay:** 1. Original - OHR, Records and Transactions Section, Certificated; 2. Copy 1 - Employee; 3. Copy 2 - School; 4. Copy 3 - PRO; 5. Copy 4 - Payroll Office, Leave Accounting Section*