



# Newark Board of Education

Dr. Yolanda Méndez, Assistant Superintendent  
Human Resource Services

Where Passion Meets Progress

## LEAVE STATUS FOLLOW-UP FORM

**MEMORANDUM TO:** Leave of Absence Unit/HRS  
Tel: 973-733-6565; 973-688-2687 Fax: 973-688-2060

**FROM:** \_\_\_\_\_  
Name of Employee

\_\_\_\_\_

Employee ID#

Location:

\_\_\_\_\_

Position:

**SUBJECT:** LEAVE STATUS

**This is to notify you that (PLEASE CHECK  ONE OF THE FOLLOWING):**

I plan to return to work on \_\_\_\_\_.

**Important: If you were absent from work for 20 or more consecutive days, you MUST provide our office with medical clearance before your intended return to work date. You MUST attach the medical clearance documentation to this form in order to be reinstated. Please fax the medical documentation and this form to 973-688-2060, or email to [leaveofabsence@nps.k12.nj.us](mailto:leaveofabsence@nps.k12.nj.us), or drop-off at Newark Board of Education, Human Resources Services, 765 Broad Street, 2<sup>nd</sup> Floor, Newark, NJ 07102.**

I would like to request an extension of my leave (what type of leave) \_\_\_\_\_  
from (mm/dd/yy) \_\_\_\_\_ to (mm/dd/yy) \_\_\_\_\_

(If for medical reasons you must include a doctor's certificate /personal reasons you must indicate why). **REMINDER you cannot extend your FAMILY MEDICAL LEAVE ACT OF ABSENCE beyond 12 weeks. If extending to a New Jersey Family Leave of Absence you must provide documentation along with this form for birth of a child copy of Birth Certificate or crib card. Comment** \_\_\_\_\_

**Please accept this form letter as my letter of:**

RESIGNATION effective \_\_\_\_\_  
(Non-Instructional - must include two (2) weeks' notice).  
(Instructional Non-Tenured - must submit 30 Calendar Days).  
(Instructional Tenured - must submit 60 Calendar Days).

RETIREMENT effective \_\_\_\_\_ **(must be on the (1<sup>st</sup>) of the month).**  
**(Per N. T. U. Contract, must give 90-day notice in advance for retirements that occur on the date other than July 1st of each year).**

Prior to your anticipated return to work date you must reach out to Benefits and Compensation to verify your health and fringe benefits coverage status. (Phone: (973-733-7336).

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_