Request for Leave of Absence

PLEASE COMPLETE AND SUBMIT THIS FORM TO YOUR IMMEDIATE SUPERVISOR, OR THE HUMAN RESOURCES DIRECTOR IF APPLICABLE, IN ADVANCE OF LEAVE REQUESTED.

EMPLOYEE INFORMATION

Employee Name (First, Last, Middle Initial)

Home Address	**City**	**State**	**Zip**

Job Title/ Department

Telephone Number _____ ☐ HOME ☐ CELL

ABSENCE INFORMATION

☐ This is a new request. ☐ This is an update to an existing request.

Requested Start Date: Anticipated Return Date:

TYPE OF LEAVE

☐ Consecutive Leave of Absence ☐ Intermittent Absence (information required below)

For Intermittent Absences, describe your intermittent or reduced work schedule (e.g., "up to 2-3 sick days a month per doctor"). This must be medically necessary and documented in a current medical certification form from your health care provider.

REASON(S) FOR LEAVE

Please indicate the applicable reason(s) for your leave below.

- ☐ Employees Own Serious Health Condition (**not work related**)*
- ☐ Care for Ill Parent, Spouse or Child – FMLA*
- ☐ Pregnancy Leave – FMLA*
- ☐ Military Caregiver – FMLA*
- ☐ Baby Bonding - Care for Newborn/Placed Child – FMLA°*

° *Provide the Date of Birth or Placement of Child*: _____

**** For leaves due to your own or a Family Member's Serious Health Condition, a Medical Certification form is likely required.***

- ☐ I will provide any/all completed Medical Certification forms required of me. *(See HR Director)*
- ☐ I will complete and sign any/all FMLA related forms required of me. *(See HR Director)*

- ☐ Workplace Injury / Worker's Compensation
- ☐ Personal Leave (Non-Medical Reason)

DISABILITY BENEFITS

☐ I will file a claim for Disability benefits.

TIME OFF

A leave of absence may consist of leave without pay and/or paid leave (vacation, sick leave, and special holiday). Paid leave may be used in accordance with applicable policy. You may use paid leave to cover the seven (7) day waiting period for Disability. I request to use the following leave categories:

Type	**Number of Hours**	**Dates: From**	**Through**
Vacation			
Sick Leave			
Compensatory Leave			
Wellness Incentive Leave			
Leave w/o Pay			

☐ **I have verified that I have sufficient accrued leave to take the above requested paid leave.**

Employee Signature: Date:	HR Approval, if required:
Supervisor Signature: Date:	Date: