Leave of Absence Request

Date of Request: __/__/____

Employee Name: ________________________________

Employee Position: ________________________________ Employee Location: Please Select

Date Leave is to Begin: __/__/____ Expected Return Date: __/__/____

If the leave is to be intermittent or on a reduced schedule, please indiciate the schedule and duration of the leave.

Reason for Leave:

☐ Personal ☐ Sabatical ☐ Sabatical

☐ FMLA: ☐ Other, Please Explain : ____________________________________

- ☐ Birth of child
- ☐ Care of a new born or placement of a child in your adoption or foster care
- ☐ Military
- ☐ Serious health condition of spouse, child or parent
- ☐ Serious health condition of employee

If the requested leave is to care for a seriously ill family member, please indicate the name of the person to be cared for and their relationship to you:
Name: ______________________________________ Relationship: ___________________________

Leave for the care of a seriously ill family member or for the employee's own illness will require completion of a Certification Form by the health care provider of the seriously ill person.

Employees who take leave for their own serious health condition will be required to provide certification from their health care provider that the employee is able to return to work, prior to the time the employee is reinstated.

_____________________________________ _____________________________________

Employee Signature Supervisor Approval

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Human Resources Section

☐ Leave is approved as requested.
☐ Leave is approved contingent upon the following: ____________________________________
☐ Leave is denied. Reason: ____

The following accured time will be utilized to ensure compensation continuance.
☐ Sick hours ___________ ☐ Vacation hours ___________ ☐ Personal hours ___________

Misc. Notes:____

Human Resources Approval: ____ Date: _________