

LEAVE OF ABSENCE APPLICATION

INSTRUCTIONS: PLEASE COMPLETE **ALL** SECTIONS ON THIS FORM. TYPE OR PRINT IN INK. COMPLETE THIS FORM EACH TIME THAT YOU A) REQUEST A LEAVE; B) WISH TO EXTEND THE DATE OF YOUR LEAVE; OR C) CHANGE FROM ONE TYPE OF LEAVE TO ANOTHER. ONCE THIS APPLICATION IS COMPLETED, PLEASE SEND THE ORIGINAL TO HUMAN RESOURCES AND GIVE A COPY OF THE APPLICATION TO YOUR SUPERVISOR.

PLEASE NOTE: ANY SUPPORTING MEDICAL DOCUMENTATION SHOULD ONLY BE GIVEN TO HUMAN RESOURCES.

1. EMPLOYEE INFORMATION

EMPLOYEE NAME: _____ HOME/CELL PHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____ ZIP: _____

2. PURPOSE OF LEAVE REQUEST

THIS APPLICATION IS FOR: INITIAL LEAVE EXTENSION OF LEAVE

I WISH TO APPLY FOR THE FOLLOWING TYPE OF LEAVE:

- EMPLOYEE'S MEDICAL DISABILITY – NON-PREGNANCY RELATED
- EMPLOYEE'S MEDICAL DISABILITY – PREGNANCY RELATED
- FAMILY CARE LEAVE – SERIOUS HEALTH CONDITION OF FAMILY MEMBER
- FAMILY CARE LEAVE – BONDING WITH NEWBORN OR NEWLY PLACED CHILD

3. REQUIREMENTS OF LEAVE

EMPLOYEE'S OWN MEDICAL DISABILITY

- ATTACH A COMPLETED "CERTIFICATE OF HEALTHCARE PROVIDER" CERTIFYING YOUR MEDICAL DISABILITY. (FORMS ARE AVAILABLE FROM HUMAN RESOURCES)

FAMILY CARE LEAVE

- ATTACH A COMPLETED "CERTIFICATE OF HEALTHCARE PROVIDER" CERTIFYING THE FAMILY MEMBER'S SERIOUS HEALTH CONDITION. (FORMS ARE AVAILABLE FROM HUMAN RESOURCES)
- ATTACH PROOF OF THE FAMILY MEMBER'S RELATIONSHIP TO YOU.

4. DATES AND SCHEDULE OF LEAVE REQUEST

REQUESTED LEAVE BEGIN DATE:		REQUESTED LEAVE END DATE:	
IF REQUESTING REDUCED OR INTERMITTENT SCHEDULE, PLEASE DESCRIBE.			

5. SIGNATURE

I UNDERSTAND THAT EACH LEAVE APPLICATION OR LEAVE EXTENSION MUST BE VERIFIED BY HUMAN RESOURCES. I UNDERSTAND THAT TO BE APPROVED FOR A LEAVE, I MUST PROVIDE DOCUMENTATION REQUIRED FOR THE TYPE OF LEAVE REQUESTED. I UNDERSTAND THAT I MUST RETURN TO WORK ON THE FIRST BUSINESS DAY AFTER MY LEAVE ENDS.

SIGNATURE _____

DATE _____