



Request for Leave of Absence

PLEASE COMPLETE AND SUBMIT THIS FORM TO HUMAN RESOURCES.

EMPLOYEE INFORMATION			
Employee Name (First, Last, Middle Initial)			
Home Address	City	State	Zip
Job Title/ Department	Telephone _____ <input type="checkbox"/> HOME <input type="checkbox"/> CELL		
ABSENCE INFORMATION			
<input type="checkbox"/> This is a new request.		<input type="checkbox"/> This is an update to an existing request.	
Requested Start Date:		Anticipated Return Date:	
TYPE OF LEAVE			
<input type="checkbox"/> Discretionary Leave of Absence		<input type="checkbox"/> Personal Leave	
<input type="checkbox"/> Consecutive Leave of Absence		<input type="checkbox"/> Intermittent Absence (information required below)	
<i>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.</i>			
REASON(S) FOR LEAVE			
Please indicate the applicable reason(s) for your leave below.			
<input type="checkbox"/> Employees Own Serious Health Condition (not work related)*			
<input type="checkbox"/> Care for Ill Parent, Spouse, Child or Domestic Partner*			
* For leaves due to your own or a Family Member's Serious Health Condition, a Medical Certification form is required.			
<input type="checkbox"/> A completed Medical Certification form is attached.			
<input type="checkbox"/> I will submit a Medical Certification form within 15 days to my department.			
<input type="checkbox"/> Workplace Injury / Worker's Compensation			
<input type="checkbox"/> Pregnancy Leave / <input type="checkbox"/> Baby Bonding (Care for Newborn/Placed Child) °			
° Provide the Date of Birth or Placement of Child: _____			
<input type="checkbox"/> Military Leave: Active Duty, Military Caregiver or FML			
<input type="checkbox"/> Personal Leave (Non-Medical Reason)			
DISABILITY BENEFITS			
<input type="checkbox"/> I will file a claim for Disability benefits or Paid Family Leave 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/PFL benefits. I request to use the following leave categories:			
Type	Number of Hours	Dates: From	Through
Vacation	_____	_____	_____
Sick Leave	_____	_____	_____
Leave w/o Pay*	_____	_____	_____
(Personnel Officer/COO signature approval required.)			
<input type="checkbox"/> I have verified that I have sufficient accrued leave to take the above requested paid leave.			
ACKNOWLEDGEMENT			
Employee Signature:		Date:	
Supervisor Signature:		Date:	
Personnel Officer/COO Signature:		Date:	