LEAVE OF ABSENCE REQUEST FOR FAMILY OR MEDICAL LEAVE

This form must be completed and returned to the Human Resources office when you request family or medical leave. If leave is for a “serious medical condition,” certification from a health care provider is required within 15 days of this request, or the leave may be delayed or denied. Please contact Kris Codron for additional information.

Employee’s Name _____________________________________________________

Date ________________________________________________________________

Department __________________________________________________________

Position Title _________________________________________________________

Hire Date ____________________________________________________________

Supervisor or Dept. Head _______________________________________________

I am requesting a leave of absence from ____________ to ______________ for the reason checked below:

(date)   (date)

____ Employee’s own serious health condition/pregnancy
____ Parental care of child following birth
____ Placement of a child with employee for adoption or foster care (under 18 years of disabled)
____ Serious health condition of employee’s spouse, same sex domestic partner, child, stepchild, parent, or parent-in-law, grandparent or grandchild
____ To care for an employee’s child with an illness or injury, that is not a “serious health condition”
____ Bereavement for the death of a family member
____ Because of any qualifying contingency arising out of the fact that the spouse, or a son, daughter or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

Is leave request for ____ a single block of time, or _____ intermittent/reduced work schedule?

Please provide an estimate of the time you will be away from work, if intermittent/reduced work schedule requested.

__________________________________________________________________________________________

__________________________________________________________________________________________

I understand that failure to return to work at the end of my approved leave period may be treated as a resignation unless an extension has been agreed upon and approved by Human Resources.

Employee’s Signature   Date

Supervisor or Dept. Head Signature   Date

Please return this form to Kris Codron, Human Resources, Box 72 or fax to 503-768-6233