APPLICATION FOR FAMILY MEDICAL LEAVE

NAME_____ DEPARTMENT _____

ADDRESS: _____

START DATE OF ANTICIPATED LEAVE: _____

EXPECTED DATE OF RETURN TO WORK: _____

REASON FOR LEAVE (EXPLAIN): _____

_____

_____

_____

_____

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent may need to be accompanied by a verifying medical certification from a physician.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation.

SIGNATURE: _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____

APPROVED BY:

_____

HUMAN RESOURCES DIRECTOR

****PLEASE ATTACH A DOCTOR'S NOTE INDICATING THE MEDICAL CONDITION AND THE RECOMMENDED DURATION OF THE LEAVE.**

HR OFFICE USE ONLY:

Hire Date: _____
# of hours worked in the 12 months prior to beginning of leave: _____