REQUEST FOR LEAVE OF ABSENCE

Staff Member Completes Sections 1 and 2
Supervisor/Manager/Department HR Completes Section 3

Section 1: PERSONAL INFORMATION (Staff Member completes Sections 1 and 2 and returns completed form to Human Resources)		
Last Name:	**First Name:**	
Home Address:	**Work Phone:**	**Building:**
Date Submitted:	**Home Phone:**	**Job Title:**
Signature:	**E-mail:**	**Hire Date:**

Section 2: STAFF MEMBER: Check the type of leave and provide documentation as indicated (contractual leave options) or FMLA

I request that my leave begin on _____ and end on _____. (If necessary, give approximate dates.)

Family Medical Leaves (required medical certifications must be returned within 15 days of receipt)		
□	**Employee Illness**	**Certificate of Health Care Provider (Form 1002-E)**
□	**Child/Parent/Spouse Illness**	**Certificate of Health Care Provider for Family Member's Illness/Injury (Form 1002-F)**
□	**Maternity**	**Certificate of Health Care Provider (Form 1002-E)**
□	**Paternity** *(Must be taken within one year of birth)*	**Certificate of Health Care Provider (Form 1002-F)**
□	**Adoption/Placement of Foster Child** *(Must be taken within one year of placement)*	**Letter of Placement**
□	**Military Caregiver**	**Certification for Serious Illness or Injury of Covered Service Member (DOL WH-385-V)**
□	**Military Exigency**	**Certification of Qualifying Exigency (DOL WH-384)**
Personal Leaves (not FMLA eligible or not FMLA related) i.e. leave options in contract		
□	**Educational**	**Letter of Acceptance from Educational Institution**
□	**Medical (non-FMLA)**	**Certification from Health Care Provider** *(Must include date condition began, probable duration, facts regarding staff member's medical condition and inability to work)*
□	**Military (non-FMLA)**	**Department of Defense Orders**
□	**Maternity (not eligible for FMLA)**	**Certification from Health Care Provider** *(including expected delivery date)*
□	**Other Personal**	
	Explanation of Request	

Section 3: HR: Complete this section		
Name (Print):	**E-mail:**	
Signature:	**Phone:**	**Date:**

If this leave is for a Family Medical Leave:

(1) Has Staff Member had absences counted towards FMLA entitlement in the past 12 months? □ **YES** □ **NO**

If so, provide dates/hours which have already been applied towards FMLA, along with supporting documentation

Dates: From _____ to _____ Total hours of FMLA utilized during the past 12 months: _____

(2) If approved, will this leave be taken on an intermittent basis? □ **YES** □ **NO**
(Not available for adoption, placement in foster care or Paternity leave; only available for maternity leave if medically necessary)

(3) Leave dates approved From _____ To _____