LEAVE OF ABSENCE REQUEST FORM

Name:_____ Date: _____

Department: _____

Type of Leave Requested:
Medical Leave (☐), FMLA Leave (☐), Personal Leave (☐), Other (☐)

Leave Start Date: _____Return Date: _____

Reason for Leave:

Read carefully the following, and initial each blank to signify understanding.

_____ I understand that my leave of absence is without pay, other than authorized in the Leave of Absence Policy, and that the duration of any leave is at the discretion of the department head. Medical and personal leave may not exceed six months; FMLA Leave cannot exceed twelve weeks.

_____ I understand that I must return to work, or request an extension, by _____ or I will be deemed to have voluntarily terminated my employment on that date.

_____ I understand that I must submit a written physician's release to the Administrative Office in order to return to work from a Medical Leave of Absence.

_____ For other than FMLA Leave, I understand that my present position may not be available either due to a need to fill the vacancy or due to a medical condition related to my release.

_____ _____
Employee Signature Date

_____ _____
Department Head Date

_____ _____
Administrative Office Date