APPLICATION FOR FAMILY OR MEDICAL LEAVE

Name: _____ Department: _____

Current 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 must be accompanied by a verifying medical certification from a physician.

Signature: _____ Date: _____

APPROVED BY:

_____
Supervisor

_____
Director of Personnel