REQUEST FOR LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993

Employee Name: _____Social Security No. _____

Department: _____Manager: _____

Type of Leave Requested: Medical-Self: _____

Medical-Family: _____

Parental: _____

-If you are requesting a medical leave, your healthcare provider must complete and return a Medical Certification Form.

-If you are requesting parental leave, please list the date of the child's birth or adoption:
_____

Leave to Commence: _____ Leave to End: _____

Duration of Leave: _____ Weeks

Last Day Worked: _____

Employee Signature: _____ Date: _____

Manager Signature: _____ Date: _____

HR Manager Signature: _____ Date: _____