

Request and Authorization for Leave

Send Completed Form to Human Resources

Please refer to the Employee Handbook for complete descriptions of the various types of leave available.

General Information

<input type="checkbox"/> HOURLY	<input type="checkbox"/> SALARIED	EMPLOYEE ID NUMBER _____	5/6/2020
Type or Print Employee Name _____			Date
Department _____		Supervisor _____	
I request leave beginning at _____ on _____, ending at _____ on _____ for			
Time Date Time Date			
a total of _____ Check <input checked="" type="checkbox"/> one of the following reasons:			
Annual Leave – Annual leave needs to be requested at least 3 working days in advance			
<input type="checkbox"/> Sick Leave - Sick leave is used when conditions do not permit the use of Family or Medical Leave			
<input type="checkbox"/> Personal Day - One day per calendar year			
<input type="checkbox"/> Emergency Leave - Up to three consecutive days per year for family members specified in Handbook			
<input type="checkbox"/> Military Leave - Up to three weeks per year			
<input type="checkbox"/> Funeral Leave - Up to three consecutive days for family members specified in Handbook			
<input type="checkbox"/> Jury Duty - Summoned to appear for jury duty			
<input type="checkbox"/> Court Leave - Subpoenaed to appear in court as a witness			
<input type="checkbox"/> Compensatory Time			
<input type="checkbox"/> Leave without Pay - for use when sick and annual leave is unavailable			
<input type="checkbox"/> Emergency Leave Paid Sick Leave			
<input type="checkbox"/> Emergency Family and Medical Leave Expansion			
Employee Signature _____			Date _____
Approved: _____			Date _____
Supervisor Signature _____			Date _____

Family or Medical Leave

I request Family or Medical Leave (FMLA) for the following reason:	
Check <input checked="" type="checkbox"/> one of the following reasons:	
<input type="checkbox"/> A serious health condition that makes you unable to perform the essential functions of your job.	
<input type="checkbox"/> A serious health condition affecting your <input type="checkbox"/> Spouse, <input type="checkbox"/> Child, <input type="checkbox"/> Parent for which you are needed to provide care.	
<input type="checkbox"/> The birth of your child, or the placement of a child with you for adoption or foster care. This leave needs to start on _____ and is expected to end on _____.	
Date Date	
Medical certification supporting the need for an employee to care for their own, or their spouse's, child's or parent's serious illness is required. Medical certification forms are available in the Human Resources Office.	
<input type="checkbox"/> Medical Certificate is attached.	
The requesting employee will be notified of the status of the request within two working days of the request being Received in the Human Resources Office.	
Employee Signature _____ Date _____	