REQUEST FOR LEAVE OF ABSENCE

Last Name: _____ First Name: _____ M.I. _____

Date of Hire: _____ Last 4 digits of SSN: _____

Position: _____ Department: _____

Supervisor: _____ Phone #: _____

Leave Start Date: _____ Leave End Date: _____

Leave Type: (Check all that apply)

- o Disability
- o Military
- o (FMLA) Family Medical Leave Act
- o Extended FMLA Dependent Care Benefit (COVID)
- o (PFL) Paid Family Leave
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- o Personal

Purpose: (Check all that apply)

- o Illness/injury/incapacitation of requesting employee
- o Care of family member with a serious health condition
- o Parental Leave (Birth, Adoption, Foster Placement)
- o COVID related
- o Other

_____

1. Have you taken a leave of absence in the past 12 months? ^ ´ E K
2. Is this a request for intermittent leave? z ^ ´ E K
3. Is this a work-related illness or injury? z ^ ´ E K If yes, please complete an injury report at t } Œ l Œ • [} u ‰ v • š] } v and submit within 5 days of the injury.