Request for Leave of Absence

SECTION 1- EMPLOYEE

Last Name	First Name	Worksite Employer
Complete Address	Phone (w)	Department
	Phone (h)	Hire Date

SECTION 2-TYPE OF LEAVE REQUESTED

☐ **Family/Medical Leave of Absence (FMLA)**

1. To be eligible for FMLA, an employee must have twelve (12) months or more of The COMPANY continuous employment (or 12 months or more combined and continuous employment at The COMPANY and Your Company AND have worked a minimum of 1,250 hours worked during the year preceding the leave.
2. The reason for leave must be an eligible reason under FMLA law.
3. Medical Certification may be required.

☐ **Non-FMLA Leave of Absence**

1. Employees who do not meet the eligibility requirements for FMLA may apply for a non-FMLA leave of absence.

SECTION 3-REASON FOR LEAVE OF ABSENCE

Family/Medical Leaves	**Leaves of Absence NOT covered under FMLA**
☐ Maternity	☐ Personal includes: ☐ Personal
☐ Paternity	☐ Educational
☐ Adoption/ Placement of Foster Child	☐ Military
☐ Child/Parent/Spouse Illness	☐ Illness/Injury (*Only if not eligible or qualified for FMLA*)
☐ Personal Illness/Injury	☐ Maternity (*Only if not eligible or qualified for FMLA*)

Estimated Leave Beginning Date: _____

Estimated Leave End Date: _____

If intermittent, please attach proposed schedule.

SECTION 4-EMPLOYEE ACKNOWLEDGMENT & SIGNATURE

1. Leave, if granted, may be used only for the purpose described above. Use of leave for any other purpose will be grounds for disciplinary action up to and including termination of employment.
2. Employee is expected to return to work upon the date of expiration of the leave of absence.
3. Request for an extension of leave of absence must be made to Your Company representative or immediate supervisor prior to the return date of the leave.
4. Employee has the responsibility for maintaining contact with Your Company Representative and/or a member of the Human Resource Department, on a periodic basis, during a leave.
5. If you are covered under an employer's health plan, you **must** contact a member of the Benefits Department to make arrangements to continue benefit/s coverage.

Employee Signature	Date

SECTION 5-MANAGEMENT APPROVALS

Supervisor: ☐ Approved ☐ Denied Reason _____ Signed _____ Date _____

Department Head: ☐ Approved ☐ Denied Reason _____ Signed _____ Date _____

Human Resources: ☐ Approved ☐ Denied Reason _____ Signed _____ Date _____

If applicable, please include a doctor's note along with this form. Please fax this form to ManagedPAY at (702) 932-5727.