



LEAVE OF ABSENCE NOTICE

Employee Information:

Name: _____ SS#: _____ - _____ - _____
Last First Middle

Address: _____ Apt. #: _____

City: _____ St: _____ Zip: _____ Phone: (_____) _____ - _____

Reason (please explain in detail): _____

Original Hire Date: ____/____/____ Anticipated Leave Date: ____/____/____ Anticipated Return Date: ____/____/____

Type of Leave (Please check one):

Family Medical Leave Act (FMLA)

Note: FMLA requires employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for at least 12 months and for 1,250 hours over the previous 12 months.)

Jury Duty

Medical Leave of Absence (not FMLA)

Military Leave of Absence (USERRA)

Personal Leave of Absence

If FMLA eligible (Please check appropriate box):

The birth of a child, or the placement of a child with you for adoption/foster care.

A serious health condition affecting your spouse, child or parent, for which you are needed to provide care.

A serious health condition that makes you unable to perform the essential functions of your job.

Note: Once the Human Resources Dept. receives your notice, you will be sent an information packet stating whether or not you are eligible for FMLA. If eligible, you will have 15 days to submit a Medical Certification completed by your Health Care Provider. If FMLA is granted, it will be based on the Medical Certification. Leave dates may be adjusted depending on when the FMLA actually occurs.

Worksite Name: _____ Phone: (_____) _____ - _____

Preparer's ID: _____ Date: ____/____/____

Preparer's Name (Printed): _____