

Request for Leave of Absence

Medical or Non-Medical

Employee Name: _____ Date of request: _____

Last day to be worked: _____, ___/___/___/ Expected return date: _____, ___/___/___/

The Family and Medical Leave Act of 1993 entitles eligible employees to take up to 12 weeks of unpaid, job-related leave each year for specified family and medical reasons if: (1) the employee has worked for the employer for at least 12 months, and (2) if the employee has worked a minimum of 1,250 hours over the previous 12 months, and (3) if the employer for which the employee works has at least 50 employees who work within 75 miles of the company's location. A covered employer must grant eligible employees up to a total of 12 workweeks of unpaid leave during any 12-month period for one or more of the following reasons: (a) for the birth or placement of a child for adoption or foster care, (b) to care for an immediate family member (spouse, child, or parent) with a serious health condition; or (c) to take medical leave when the employee is unable to work because of a serious health condition. **Employees working for exempt employers, and/or employees not meeting the eligibility requirements, do not qualify for the provisions of The Family and Medical Leave Act of 1993.**

REQUEST FOR:

<input type="checkbox"/> NON-MEDICAL LEAVE OF ABSENCE	REASON: _____
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Under special circumstances an employer may be granted a non-medical leave of absence without pay. The granting of this type of leave is normally for compelling reasons and is dependent upon submission of this Request for Leave of Absence with a minimum of 30 days advance notice and contingent on written approval of management.

<input type="checkbox"/> FAMILY AND MEDICAL LEAVE OF ABSENCE	REASON: _____
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MEDICAL REASON:

Maternity Illness Worker's Comp Other: _____

I understand that my employer will make reasonable efforts to return me to the same or similar job as held prior to the leave of absence, subject to staffing and business requirements, unless state law dictates otherwise.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

Approved Denied _____ DATE: _____
Management Signature: