

# 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)

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

Purpose: (Check all that apply)

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

1. Have you taken a leave of absence in the past 12 months?  Yes  No
2. Is this a request for intermittent leave?  Yes  No
3. Is this a work-related illness or injury?  Yes  No  
If Yes, please complete an injury report to be filed within 5 days of the injury.