**LEAVE OF ABSENCE FORM**

**NOTICE – You are required to complete this form if you are requesting a leave of absence.**

I am requesting a leave of absence for the following reason:

I have a serious health condition and do not qualify for FMLA;

I have a serious health condition and have exhausted FMLA;

One of my immediate family members has a serious health condition and I need to provide care to this family member. FMLA is not available for this leave.

**Dates of Absence:**

Leave Start Date:

Leave End Date:

If you’re uncertain of exact dates, please use approximate or estimated dates that you will be away from work.

I acknowledge that I have read the Leave of Absence policy and understand that the maximum length of my leave is eight (8) weeks. I agree to provide HR with a completed physician form that indicates I have been released to return to work (if this leave is for my own serious health condition). In addition, I understand that I am required to use all paid leave that is available to me prior to taking an unpaid leave.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature

Approved by:

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Manager Department Head

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HR Director