# SAMPLE ADMINISTRATIVE FORM

## REQUEST FOR FAMILY OR MEDICAL LEAVE

*Please Print*

Request for Family or Medical Leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hire Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of Service: \_\_\_\_\_\_\_\_

Status: [ ] Full Time [ ] Part Time [ ] Temporary Employee Payroll #: \_\_\_\_\_\_\_\_\_\_\_

I request family or medical leave for one or more of the following reasons:

[ ] Because of the birth of my child and in order to care for him or her.

Expected date of birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Actual date of birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Leave to start: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Expected return date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

[ ] Because of the placement of a child with me for adoption or foster care.

Date of placement: \_\_\_/\_\_/\_\_\_

Leave to start: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Expected return date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

[ ] For a serious health condition that makes me unable to perform my job.\*

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Leave to start: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Expected return date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

\* A physician’s certification may be required for leave due to a serious health condition.

[ ] For other reasons:

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Leave to start: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Expected return date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

[ ] Requested intermittent leave schedule (if applicable; subject to employer’s approval): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you taken a family or medical leave in the past 12 months? [ ] Yes [ ] No

If yes, how many work days? \_\_\_\_\_

I understand and agree to the following provisions:

[ ] I have worked for my employer at least one year and at least 1,250 hours in the previous twelve months.

[ ] If I fail to return to work after the leave for reasons other than the continuation or onset of a serious health condition that would entitle me to medical leave or other circumstances beyond my control, and if my employer requires it, I will be financially responsible for the medical insurance premiums the company paid while I was on leave.

[ ] This leave will be unpaid, unless it is company policy to be paid; or in the case of my own disability, payment will occur under a company disability insurance plan, if I am so covered.

[ ] I may be required to exhaust my paid vacation, personal or sick leave as part of my 12 weeks of leave.

[ ] After 12 weeks of leave, if I do not return to work or contact my supervisor or manager on the date intended, it will be considered that I abandoned my job.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**Leave Approval**

For full day leave:

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

For intermittent or reduced day leave:

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Personnel Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Payroll Instructions**

[ ] With pay from: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ [ ] Without pay from: \_\_\_/\_\_\_/\_\_ to \_\_\_/\_\_\_/\_\_

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_