New ___

Extension or Change ___

Request/Leave of Absence Form

Employee _________________________ Soc. Sec. #_____________________

Employee's Title_______________________Supervisor Name ___________________

Type of Leave: Personal ____Sick____Maternity____Other____

Date of Request____________ Dates of Leave: From:___________To:___________

Purpose of Request____

Doctor Certification Received: ______

Hours or Days of Sick Pay Requested_____ Vacation Hrs. Requested ______

Other _____________

______________________________ ______________________
Employee's Signature Date

____________________________________ ______________________
Supervisor/Administrator Signature Date

____________________________________ ______________________
Central Office Signature Date

Approved ___ Denied____ Reason____________________________________

Copy to: Human Resources, Administrator, Employee

Note: A note from physician should accompany this form. This may be counted towards family medical leave during the calendar year.