Application for a Leave of Absence

Name: _____ Department: _____

Address:_____ Extension: _____

_____ Home Phone: _____

Reason for this Request

Medical _____ Family Leave _____ Personal _____ Military _____

Maternity _____ Paternity_____ Adoption _____ Family Military Leave_____

Duration of Leave

Starting Date: _____ Returning Date: _____

In conjunction with this leave, I am requesting to use:

_____ earned vacation days
(# of days)

_____ earned sick days
(# of days)

_____ earned personal days
(# of days)

An application for a leave of absence for medical reasons must be accompanied by a Certification of Health Care Form, indicating the diagnosis, prognosis, and projected date of return. If the application is for a maternity leave, your doctor's statement must include the anticipated date of delivery, the length of time you can medically work prior to the delivery and the length of time you will medically need after the delivery.

If this request is approved, I agree to accept the following conditions: (a) upon expiration of this leave (medical or maternity only) I agree to furnish the Office of Human Resources with a physician's statement indicating that I am now medically able to return to work; (b) if I fail to return to work on the dates scheduled, without receiving an approved extension from my supervisor and the Office of Human Resources, it will be construed as a resignation of my employment; (c) if my leave is unpaid and I participate in the College's benefit programs (health, dental, etc.), it is my responsibility to make arrangements with Human Resources to continue my monthly payments while on leave.

Employee: _____ Date: _____

Department Head: _____ Date: _____

For HR Use:

This is a paid leave _____ unpaid leave _____ or partially paid leave _____.

This leave is classified as a family medical leave (FMLA): yes _____ no _____.

Human Resources: _____ Date: _____