MEDICAL LEAVE REQUEST

(To be used for employee or family illness)

TO BE COMPLETED BY EMPLOYEE

NAME _____   REGULAR DAYS OFF _____   SHIFT _____

DEPT/DIV _____   POSITION _____

I AM REQUESTING MEDICAL LEAVE FOR   MYSELF   SPOUSE   PARENT   CHILD

BEGINNIN_____   DATE _____   AND ENDING AT _____   DATE _____

TOTAL NUMBER OF HOURS LEAVE _____   COMMENTS: _____

I hereby request medical leave with pay and certify that either I had an appointment for medical treatment or was ill and unable to report to work, or that my spouse, parent, or child was ill. I further certify that I did not perform other services for pay on the hours listed above. I understand that falsification of the medical leave request or abuse of medical leave privileges shall be grounds for disciplinary action or discharge.

_____

SIGNATURE OF EMPLOYEE   DATE

NOTE: **SEE APPLICABLE PERSONNEL RULES FOR ALL TYPES OF ABSENCES.**

Step 1.   Employee should complete this form, if possible, prior to date of absence. If not, this form shall be completed upon return to work. Employees who take leave for their own illness may be required to present medical certification that they are able to perform the essential functions of their job prior to being returned to work. Medical Leave absences not requiring medical attention shall be reported at the beginning of each absence and each consecutive morning thereafter.

Step 2.   Employees are responsible for monitoring of their leave accrual and usage. By signing this form, the employee acknowledges verification of sufficient accrued leave for the absence at the time the leave is taken. If said accrued leave time is insufficient for the absence, the employee may be denied leave or charged as absent without leave.

Step 3.   Completed forms will substantiate absences noted on payroll.

TO BE COMPLETED BY SUPERVISOR

IS THE ABSENCE DUE TO A SERIOUS ILLNESS OF EMPLOYEE, SPOUSE, PARENT, CHILD OR THE BIRTH/ADOPTION OF A CHILD OR MILITARY CAREGIVER LEAVE UNDER THE TERMS OF THE FAMILY AND MEDICAL LEAVE ACT.

YES   NO

EMPLOYEE'S INITIALS _____

IF SO, DATE HUMAN RESOURCES WAS NOTIFIED: _____   DATE: _____

APPROVED BY:

_____   Date _____
SUPERVISOR

_____   Date _____
MANAGER

_____   Date _____
DEPARTMENT HEAD

This Form is a Public Record