Request for Leave Form

Employee ____ Date ______________________________

I am hereby requesting the following leave, reduced work schedule, and/or intermittent leave hours as follows:

Annual Leave: for	Vacation Tardy	Other
Sick Leave: for	Personal illness, disability Medical appointment, self Medical appointment, family	Family illness Death Maternity/Paternity

Comp Time

Jury Duty

Workers' Compensation

FMLA requested (fill in bottom part of page if this block is checked.)

Date(s) and/or time of leave requested from ____

to ____ . Total number of hours requested __________ .

____________________________________ ____________________________________

Employee's signature *Supervisor or Department Head's Signature*

FMLA Notification

Under the Family and Medical Leave Act (FMLA) you are entitled to 12 weeks due to 1) the birth of a child or a placement of a child for adoption or foster care; or 2) a serious health condition for which you need care; or 3) a serious health condition affecting your spouse, child, or parent for which you are needed to provide care.

If your leave request meets any of the criteria listed above, and you are on leave without pay, the county may designate the requested leave time, reduced hour work schedule and/or intermittent leave hours as part of any entitlement you may have under the FMLA. For more detail, see the Personnel Policy.

Explanation

In order that the department be able to plan for and distribute your workload during the time requested to be on leave days, reduced hour work schedule, and/or intermittent leave, it is imperative that you explain in detail and give specific information, below, concerning the requested work hours and/or time absent from work. (If additional space is needed, use back of this form.)

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