Application for Family or Medical Leave

Name: _____ Department: _____

Current Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (Explain): _____

_____

_____

_____

_____

NOTE: A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician.

I hereby authorize **[the company]** to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by **[the company]**.

Signature: _____ Date: _____

APPROVED BY:

_____

Supervisor

_____

Director of Personnel