Request for Medical Leave*

EMPLOYEE INFORMATION			
Employee Name (First, Last, Middle Initial)			
Home Address	**City**	**State**	**Zip**
Job Title/ Department	**Telephone Number** ☐ HOME ☐ CELL		

ABSENCE INFORMATION	
☐ This is a new request.	☐ This is an update or extension to an existing request.
Requested Start Date:	Anticipated Return Date:

REASON(S) FOR LEAVE

Please indicate the applicable reason(s) for your leave below.

- ☐ Employees Own Serious Health Condition
- ☐ Care for Ill Parent, Spouse/Partner, Child or Partner
- ☐ Maternity/Child Care/Adoption or Foster Leave

LEAVE OF ABSENCE CATEGORIES

Employee Signature: Date:	Employer Signature: Date:

***If applicable please also include with this request the verification from your healthcare provider required by Section III(B) of the School's Medical Leave Policy.**