



REQUEST FOR LEAVE OF ABSENCE

Employee Name: _____

Department: _____

Reason for Request (check one):

_____ FMLA:
Care of seriously ill child, spouse or parent. FMLA forms received _____

_____ Personal

_____ Military

_____ Humanitarian

Requested Dates:

Start: _____ End: _____

Supporting Documents Submitted?:

_____ Yes _____ No

Employee's Signature

Date