

People's Place Family Medical Leave Request Form

Employee Name _____

Payroll Number _____

Program _____

Date: _____

I am requesting a leave of absence for the reason so designated and understand that the leave cannot exceed twelve weeks, 480 hours of leave. It is my intention to return to work at the end of the leave period.

Requested Leave Dates:

Leave Begin Date: _____

Leave End Date: _____

Please check one in each category:

Leave Reason

Leave Type

Time Requested

Birth or Adoption

Continuous

Care of Child

Intermittent

Days _____

Care of Parent

Reduced Schedule

Hours _____

Care of Spouse

Weeks _____

Employee Medical Condition

Military Leave

I understand that I will be reinstated to my same position, or an equivalent position, with equivalent pay, benefits and other employment terms and conditions.

I also understand that failure to return from the approved Family and Medical Leave within the agreed upon timeframe may constitute a voluntary termination.

I have read the handout "Your Rights under the Family and Medical Leave Act of 1993 and People's Place Leave Policy #110 and I am aware of my responsibilities.

LEAVE WILL BE PAID ONLY IF EMPLOYEE HAS SUFFICIENT AND APPROPRIATE ACCRUALS TO COVER PART OR ALL OF THE ABSENCE. LEAVE MAY BE USED AS OUTLINED IN LEAVE Policy #110.

Employee Signature

Request Date

Supervisor/Program Director Signature

Date

Received in HR by:

Date Received