APPLICATION FOR FAMILY AND MEDICAL LEAVE (FML)

Name: _____ Department: _____

Current Address: _____

_____

Date of Anticipated Leave: _____

Expected Date of Return from Leave: _____

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.* *You are required to submit this form in a timely manner. Failure to provide a complete and sufficient medical certification may result in a denial of your FML request.*

I hereby authorize my supervisor to contact my physician, if necessary.

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 my supervisor.

Employee's Signature: _____ Date: _____

APPROVED BY:

Supervisor's Signature _____ Date _____