FAMILY MEDICAL LEAVE REQUEST FORM

Employee Name: _____

Date of Hire: _____

Department: _____ Manager: _____

How many hours per week do you currently work: _____

Reason for use of Family Medical Leave:

Expected duration of leave

Expected date leave will begin: _____

Expected date of return: _____

Employee Signature: _____ Date: _____

Manager Signature: _____ Date: _____

HR Use only:

Date form was received: _____

Leave approved/Not approved: _____

Medical documentation received: _____

Comments: _____