PERRY CITY
REQUEST FOR LEAVE OF ABSENCE

EMPLOYEE REQUEST

Name	Address	Telephone Number
Social Security Number	**Position**	**Hire Date**
Department	**Last Date Worked**	

Request is made for leave of absence: ☐ with pay ☐ without pay

TYPE:

☐ Disability (including pregnancy) ☐ Emergency leave ☐ Other:_____
☐ Disability (Workers Comp) ☐ Military Leave
☐ FMLA ☐ Personal Leave (Not to exceed _____ Days)

Dates		Purpose
Start	**Return**	

I understand that the leave, if granted may be used only for the purpose described above and use of the leave for any other purpose will be grounds for disciplinary action up to and including dismissal.

Employee Signature Date

PHYSICIAN

If request for leave is due to medical disability, your physician must complete the following:

The above-named is a patient in my care and is expected to be released to full duty on or about: / /

Physician Address

Physician Signature Date Physician Phone

APPROVAL

ELECTED OFFICIAL/DEPARTMENT HEAD		PERSONNEL	
	DATE:		DATE:
☐ APPROVED	____/____/_____	☐ APPROVED	_____/____/_____
☐ APPROVED WITH CONDITION(S)	____/____/_____	☐ APPROVED WITH CONDITION(S)	____/____/_____
☐ DENIED	____/____/_____	☐ DENIED	____/____/_____
If denied, reason or if conditional, reason:		If denied, reason or if conditional, reason:	

_____ _____

Elected Official/Department Head Signature Personnel Signature

NOTICE

TO THE EMPLOYEE:

The date of expiration of your Leave of Absence is the date you are expected to return to work. Request(s) for Extension of Leave of Absence must be made to the Personnel Department before your approved return date. You have the responsibility for maintaining contact with the Personnel Department.

ADDRESS AND TELEPHONE NUMBER OF WHERE YOU MAY BE CONTACTED: