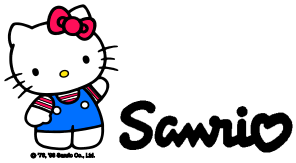

REQUEST FOR LEAVE

Name: _____

Social Security No: _____

Department: _____

Duration: _____
(specify in days, weeks, or months)

Leave Start Date: _____

Ending Date of Leave: _____

Employee Signature: _____

I am requesting leave for the following reason(s): (specify)

☐ Pregnancy Disability or Related-Medical Condition.

☐ Care of my infant after childbirth (CFRA).

☐ Adoption or foster care placement of a child in my home.

☐ My own serious health condition which renders me unable to perform the essential functions of my position.

☐ A serious health condition affecting my ☐ spouse, ☐ child, ☐ parent, for which I am needed to provide care.

☐ Military service.

☐ Personal/Other (specify)

_____

_____

_____ _____
Received By Date

_____ _____
Human Resources Manager Date