



Request for Leave of Absence

Employee Name: _____

Social Security #: _____

Title: _____

Worksite

Employer Name: _____

Today's Date: ____/____/____

Leave Begin Date: ____/____/____

Return to Work Date: ____/____/____

If it is determined that I am unable to return to work on this date, I agree to contact my employer immediately and complete a new Request for Leave of Absence form if required.

Section 2: FAMILY MEDICAL LEAVE (FMLA)

(I understand that approval of leave may be conditional on additional verification documentation)

- The birth of a child.
The expected delivery date is ____/____/____
- The placement of a child with you for adoption or foster care.
The child was/will be adopted or placed with me on or around ____/____/____
- A serious health condition that makes you unable to perform the essential functions of your job.
- A serious health condition affecting a family member for which you are needed to provide care.
Family Member Name: _____ Relationship: _____

Comments: _____

Section 3: MILITARY LEAVE

- Active and/or Reserve Service (attach a copy of your military service orders)

Section 4: PERSONAL LEAVE

- Explanation: _____

Section 5: SIGNATURE

I understand that I may be required to use all or part of any accrued paid time off during my leave and that I will be required to pay my portion of any health insurance benefits that may be continued during my leave.

Employee Signature: _____ Date: ____/____/____

Supervisor Signature _____ Date: ____/____/____

RETURN FORM TO:

**INNOVATIVE EMPLOYER SOLUTIONS
2836 5TH AVENUE NORTH, ST. PETERSBURG, FL 33781
FAX 727-323-7999**

R-25.0

