

# Extended Medical Leave of Absence Form

Instructions: Please complete this form to request an extended medical leave of absence. Once filled out, print the form and obtain the necessary signatures before submitting it to the Human Resources department along with your medical documentation.

## 1. Employee Information

Full Name:

Employee ID:

Job Title:

Department:

Phone Number:

Email Address:

## 2. Leave Request Details

Requested Leave Start Date (MM/DD/YYYY):

Expected Return to Work Date (MM/DD/YYYY):

Type of Medical Leave (e.g., Personal Illness, Family Medical Leave):

Brief Description of Request (Optional):

## 3. Medical Practitioner Information

Physician / Practitioner Name:

Medical Facility / Clinic:

Practitioner Phone Number:

## 4. Acknowledgement and Signatures

By signing below, I certify that the information provided on this form is accurate and that I am requesting leave for legitimate medical reasons. I understand that medical certification may be required to support this request.

Employee Signature:  Date (MM/DD/YYYY):

Supervisor / Manager Signature:  Date (MM/DD/YYYY):

HR Representative Signature:  Date (MM/DD/YYYY):