

# Standard Employee Medical Leave Request Form

Instructions: Please complete all sections of this form. Once filled out, print the form and submit it to the Human Resources department along with the required medical documentation.

## 1. Employee Information

Full Name:

Employee ID:

Job Title / Position:

Department:

Manager / Supervisor Name:

Phone Number:

Email Address:

## 2. Leave Request Details

Reason for Medical Leave (e.g., Personal Illness, Injury, Maternity/Paternity, Family Care):

Leave Start Date (MM/DD/YYYY):

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

Total Number of Requested Business Days:

Is this request for intermittent leave? (Yes / No):

## 3. Medical Practitioner Information

Attending Physician / Healthcare Provider Name:

Medical Facility / Clinic Name:

Facility Contact Number:

## 4. Acknowledgement and Signatures

By signing below, I certify that the information provided on this form is true and accurate to the best of my knowledge. I understand that medical leave is subject to approval and may require official supporting medical documentation.

Employee Signature:

Sign here after printing

Date (MM/DD/YYYY):

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## 5. For HR and Administration Use Only

Received By (HR Representative Name):

Date Received (MM/DD/YYYY):

Leave Request Status (Approved / Denied / Pending):

Authorized HR Signature:

Sign here after printing

Date Approved/Denied (MM/DD/YYYY):