Temporary Disability Leave Request Form

Instructions: Please complete all sections of this form. This form is intended for print and manual processing. Please submit the completed form to the Human Resources department along with your medical certification.

1. Employee Information

Full Name: _____

Employee ID Number: _____

Department: _____

Job Title: _____

Phone Number: _____

Email Address: _____

2. Leave Request Details

First Day of Requested Leave: MM/DD/YYYY

Expected Return to Work Date: MM/DD/YYYY

Type of Disability Leave requested: e.g. Short-term, pregnancy-related, etc.

3. Medical Provider Information

Physician / Medical Professional Name: _____

Medical Facility Name: _____

Facility Phone Number: _____

4. Acknowledgement and Signatures

By signing below, I certify that the information provided on this form is true and correct. I understand that medical certification from my healthcare provider is required to support this request and must be attached to this form.

Employee Signature: _____ Date: MM/DD/YYYY

Supervisor Signature: _____ Date: MM/DD/YYYY

HR Representative Signature: _____ Date: MM/DD/YYYY