

# Medical Leave of Absence Request Form

Instructions: Please complete all sections of this form to request a medical leave of absence. Once filled out, print the form and submit it to the Human Resources department along with any required medical certification.

## 1. Employee Information

Employee Full Name:

Employee ID:

Job Title:

Department:

Phone Number:

Email Address:

## 2. Leave Request Details

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

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

Total Number of Requested Leave Days:

Type of Leave (e.g., Continuous or Intermittent):

## 3. Reason for Leave

Please provide a brief explanation of the medical necessity for this request (do not disclose specific medical diagnoses):

## 4. Acknowledgement and Signatures

By signing below, I certify that the information provided is accurate and that I will provide required medical documentation from my healthcare provider within 15 calendar days.

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

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

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