

Medical Leave Extension Request Form

Instructions: This form is to be completed by the employee requesting an extension of their medical leave. Please print this form, have your medical practitioner complete the certification section, and submit it to Human Resources prior to your current leave expiration date.

Employee Information

Employee Full Name:

Employee ID:

Job Title:

Department:

Contact Phone Number:

Email Address:

Current Leave Information

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

Current Scheduled Return Date (MM/DD/YYYY):

Requested Extension Details

Proposed New Return to Work Date (MM/DD/YYYY):

Reason for Extension Request:

Medical Practitioner Certification

To be completed by the attending healthcare provider.

Physician / Practitioner Name:

Medical License Number:

Clinic / Hospital Name:

Practitioner Phone Number:

Medical Reason for Extension (Brief Description):

Signatures and Authorizations

Employee Signature

Printed Name:

Signature:

Date (MM/DD/YYYY):

Medical Practitioner Signature

Printed Name:

Signature:

Date (MM/DD/YYYY):

HR / Manager Approval

Printed Name:

Signature:

Date (MM/DD/YYYY):