Name	Employee Identification Number
Department	

Type of Leave	Date From	Date To	Time From	Time To	Total Hours
Accrued Sick Leave					
Advanced Sick Leave					

Purpose

- ☐ Illness/injury/incapacitation of requesting employee
- ☐ Medical/dental/optical examination of requesting employee
- ☐ Care of family member, including medical/dental/optical examination of family member, or bereavement
- ☐ Care of family member with a serious health condition
- ☐ Other

Family and Medical Leave

If sick leave is to be used under the Family and Medical Leave Act of 1993, please provide the following information:

I hereby invoke my entitlement to Family and Medical Leave for:

- ☐ Birth/Adoption/Foster Care
- ☐ Serious health condition of spouse, son, daughter, or parent
- ☐ Serious health condition of self

Remarks

Certification: I hereby request leave as indicated above and certify that such leave is requested for the purpose(s) indicated. I accept that falsification of information on this form may be grounds for disciplinary action. Additional documentation may be required for final approval.

Employee Signature	Date

☐ **Approved** ☐ **Disapproved** *(If disapproved, provide a reason)*

Reason for Disapproval

Supervisor Signature	Date