Request for Leave

Name: _____ Social Security #: _____

Department: _____ Employee #: _____

Reason For Leave:

_____ Birth of a Child _____

_____ Adoption of a Child _____

_____ Foster Care of a Child _____

_____ Serious Health Condition of: _____ Employee _____

_____ Spouse _____

_____ Parent _____

Date Leave is to Begin: _____

Date Leave is to End: _____

Health Benefit premiums must be paid during your Leave. Please choose one of the following payment options:

☐ Weekly ☐ Monthly ☐ In Full

Amount Due: $_____ $_____ $ _____

_____

Signature of Department Manager

_____

Approval of General Manager