LEAVE REQUEST FORM

Employee Name: _____

Worksite Employer: _____ Date of Hire: _____

I request a leave of absence for the following reason:

- ☐ Serious health condition*
  Circle one: *Employee* *Family member*
- ☐ Birth of child/placement of child for adoption or foster care*
- ☐ Active military duty*
  Circle one: *Employee* *Family member*
- ☐ To care for a covered service member with a serious injury/illness*
- ☐ Other (i.e. Vacation, Bereavement, Jury Duty)
  Please specify: _____

**If leave qualifies under the Family Medical Leave Act (FMLA), additional paperwork may need to be completed and will be provided by a Servant HR Representative.*

Anticipated dates of leave (provide estimated dates if exact dates are unknown):

Begin: _____ End: _____

*****IMPORTANT*****

I understand that I am responsible for covering any missed insurance premiums while on a leave of absence. These premiums are due by the first of the month. I understand that I have a 30-day grace period in which to make premium payments. If payment is not made timely, my insurance may be cancelled, retroactive to the last premium paid, or at Servant HR's option, Servant HR may pay my share of the premiums during my leave and recover these payments from my first paycheck(s) upon my return to work, crediting them to my worksite employer.

Employee's Signature: _____ Date: _____

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☐ Approved ☐ Pending ADA or Medical Certification ☐ Denied

Reason for denial (if applicable): _____

Supervisor's Signature: _____ Date: _____