

**Exempt Administrator Leave-Absence Request & Authorization**

Any medical information is confidential and must be kept in separate files with limited access

Name \_\_\_\_\_ ID Number \_\_\_\_\_ Work # \_\_\_\_\_

Department & Division \_\_\_\_\_

I understand that leave must be requested and approved in advance, where foreseeable. I understand that I must provide sufficient information so the proper type of leave can be determined. I understand that I am responsible for keeping my supervisor informed of any change in this request. If a medical condition is highly sensitive, contact Human Resource Services as soon as possible for guidance on other benefits available.

I request approval for \_\_\_\_\_ total hours as listed below. Is the absence due to a work-related illness or injury?  No  Yes

Record dates and number of hours in the blanks before each applicable reason. (More information may be required.)

Actual Dates and Times		# of Hours	
From	To		
_____	_____	_____	<b>Vacation</b> (Not related to care/treatment of a medical condition or bonding with a new child)
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	<b>Medical</b> If not self, relationship _____ Routine eye, medical, dental exam. Common illness/injury (no prescribed treatment, e.g. cold, flu). Other medical (inpatient or continuing treatment, e.g. surgery, childbirth).
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	<b>Other</b> (Explain reason & relationship, e.g., bonding, funeral, jury, adoption, consulting)

Explain Reason: \_\_\_\_\_

Explain Reason: \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Check Here if Form Amended

**To Be Completed By Appointing Supervisor** – Indicate type of leave of absence approved and the number of hours by type.

___ Annual	___ FML –annual	A Medical certification <input type="checkbox"/> is required <input type="checkbox"/> is not required. Required for more than 3 full consecutive working days
___ Sick	___ FML - sick	A Fitness-to-Return certification <input type="checkbox"/> will be <input type="checkbox"/> will not be required before returning to work on a regular basis.
___ Family Sick	___ FML – family sick	(Required for an absence of more than 30 days)
___ STD	___ FML – STD	
___ Military	___ FML – Military Family	
___ Bereavement	___ FML – Military Caregiver	
___ Alt. Holiday	___ FML – Holiday	
___ Unpaid	___ FML – Unpaid	
___ Administrative	___ Admin-school	
___ Jury	___ Admin – volunteer	
___ LWOP	___ Voluntary Furlough	
___ Compensatory Time (if eligible)		
___ Other Specify _____		

**Supervisor Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**To be completed by Human Resource Services:**  
For purposes of family medical leave designation, I have determined the following:

- Employee is not eligible for family – medical leave until \_\_\_\_\_ (date)
- Employee is eligible, but has already used the hours allowed in this fiscal year.
- Event does not qualify for family-medical leave
- Employee is eligible for family-medical leave AND the event does, or could, qualify for this leave.
- Continuation of a previously designated event (continuing treatment or recovery)

\_\_\_\_\_  
Director of Human Resource Services/Designee Date