

REQUEST FOR MEDICAL LEAVE OF ABSENCE

HIRE DATE: _____ DATE: _____

NAME _____ S.S. NO.: _____

LOCATION: _____

TYPE OF LEAVE OF ABSENCE: _____ MEDICAL _____ WORKERS COMPENSATION

COMMENTS: _____

LAST DAY WORKED: _____ FIRST DAY OFF: _____

ESTIMATED RETURN DATE: _____

NEW REQUEST: _____ EXTENSION: _____ RETURN NOTICE: _____

APPROVALS:

SUPERVISOR: _____ DATE _____

EMPLOYEE: _____ DATE: _____

COPIES TO: PAYROLL DEPARTMENT, SUPERVISOR, AND EMPLOYEE