Request for Leave of Absence Form

PLEASE COMPLETE AND RETURN THIS FORM TO YOUR SUPERVISOR 30 DAYS IN ADVANCE OF LEAVE IF POSSIBLE

EMPLOYEE INFORMATION

Employee Name (First, Last, Middle Initial)

Address while on leave:

Job Title/Department	Telephone Number _____ ☐ HOME ☐ CELL

ABSENCE INFORMATION

☐ This is a new request.	☐ This is an update to an existing request.
☐ Request Leave of Absence **WITHOUT** Pay	☐ Request Leave of Absence **WITH** Pay
Requested Start Date:	Anticipated Return Date:

TYPE OF LEAVE

☐ Extended Leave of Absence	☐ Intermittent Absence (information required below)

For Intermittent Absences, describe your intermittent or reduced work schedule (e.g., "up to 2-3 sick days a month per doctor").

REASON(S) FOR LEAVE

Please indicate the applicable reason(s) for your leave below.

- ☐ FMLA: Employee's Own Serious Health Condition*
- ☐ FMLA: Care for ill Parent, Spouse, Child*
- ☐ FMLA: Bonding with newborn or adoption (Leave without Pay or annual leave only)
- ☐ FMLA: Military qualifying event

*** *For leaves due to your own or a family member's serious health condition, a Medical Certification form is required.***

- ☐ On the Job Injury
- ☐ Military
- ☐ Job related education
- ☐ Administrative
- ☐ Other:

LEAVE OF ABSENCE UNDERSTANDING

I have read and understand the full content of the City of Clarksville's Administrative Policy on Leave of Absence (91-6) and City of Clarksville Code Sec. 1.5-607. I further understand that if I am absent (non-FMLA), without approval, for a period of three (3) working days, it will be considered as job abandonment and I may be terminated from employment. I also understand that the City will not pay insurance premiums if I go on Leave without Pay (non-FMLA) for an entire calendar month, but I may continue medical/pharmacy and dental under COBRA.

Employee Signature	Date:
Supervisor/Department Head Signature	Date: