REQUEST FOR LEAVE OF ABSENCE

Staff Member Completes Sections 1 and 2
Supervisor/Manager/Department HR Completes Section 3

Section 1: PERSONAL INFORMATION (Staff Member completes Sections 1 and 2 and returns completed form to Supervisor/Manager)		
Last Name:	**First Name:**	
Home Address:	**Work Phone:**	**Department:**
Date Submitted:	**Home Phone:**	**Job Title:**
Signature:	**E-mail:**	**Hire Date:**

Section 2: STAFF MEMBER: Check the type of leave and provide documentation as indicated		
I request that my leave begin on _____ and end on _____. (If necessary, give approximate dates.)		
Family Medical Leaves (required medical certifications must be returned within 15 days of receipt)		
□	**Employee Illness**	**Certificate of Health Care Provider (Form WH-380E)**
□	**Child/Parent/Spouse Illness**	**Certificate of Health Care Provider for Family Member's Illness/Injury (Form WH-380F)**
□	**Maternity**	**Certificate of Health Care Provider (Form WH-380F)**
□	**Paternity** *(Must be taken within one year of birth)*	**Certificate of Health Care Provider (Form WH-380F)**
□	**Adoption/Placement of Foster Child** *(Must be taken within one year of placement)*	**Letter of Placement**
□	**Military Caregiver**	**Certification for Serious Illness or Injury of Covered Service Member (DOL WH-385-V)**
□	**Military Exigency**	**Certification of Qualifying Exigency (DOL WH-384)**
Personal Leaves (not FMLA eligible or not FMLA related)		
□	**Medical (non-FMLA)** *(Only available for staff member's own illness/injury)*	**Certification from Health Care Provider** *(Must include date condition began, probable duration, facts regarding staff member's medical condition and inability to work)*
□	**Military (non-FMLA)**	**Department of Defense Orders**
□	**Maternity (not eligible for FMLA)**	**Certification from Health Care Provider** *(including expected delivery date)*
□	**Other Personal**	**Explanation of Request**

Section 3: SUPERVISOR/MANAGER/DEPARTMENT HR: Complete this section		
Name (Print):	**E-mail:**	
Signature:	**Phone:**	**Date:**
Name(s) and E-mail(s) of any others to receive Determination Form:		
Location within the Diocese: _____		