



Request to Be Absent ~ Absences 5 or More Days

CONFIDENTIAL & TIME SENSITIVE

**PLEASE COMPLETE THIS FORM AND RETURN TO THE BENEFITS SPECIALIST
AT CENTRAL OFFICE 30 DAYS IN ADVANCE OF LEAVE IF POSSIBLE.**

EMPLOYEE INFORMATION		
Employee Name:	Employee #:	Date:
Work Location:	Position:	
Telephone Number:	<input type="checkbox"/> HOME <input type="checkbox"/> CELL	

ABSENCE INFORMATION	
<input type="checkbox"/> With Pay	<input type="checkbox"/> Without Pay
Absence Start Date:	Anticipated Last Day Absent:
<i>(Doctor's Disability Release Form <u>must</u> be on file prior to return to work)</i>	
Name of Substitute (if available):	

TYPE OF ABSENCE	
<input type="checkbox"/> Absence 5/+ Days	<input type="checkbox"/> Intermittent Absence* <small><i>(Please note additional information required below)</i></small>
* For Intermittent Absences, describe your intermittent or reduced work schedule (e.g., "up to 2-3 sick days a month per doctor"). Intermittent absences must be medically necessary and documented in a current "Certification of Health Care Provider..."	

REASON(S) FOR LEAVE
<p><i>Please indicate the applicable reason(s) for your leave below.</i></p> <p><input type="checkbox"/> Employee's Own Medical or Sick Leave</p> <p><input type="checkbox"/> Personal or Medical Leave for Immediate Family</p> <p><input type="checkbox"/> Childbearing Leave</p> <p><input type="checkbox"/> Child-Rearing Leave <i>(Leave Without Pay)</i></p> <p><input type="checkbox"/> Military Leave</p> <p><input type="checkbox"/> Other – Please Specify: _____</p>

EMPLOYEE SIGNATURE:	
<i>Employee:</i>	<i>Date:</i>

APPROVALS:	
<i>Building Principal/Supervisor:</i>	<i>Date:</i>
<i>Human Resources:</i>	<i>Date:</i>

For Office Use Only:
<i>Accrual Balances:</i>
<i>Sick:</i>
<i>Personal:</i>
<i>Vacation:</i>