

**Sample Form #1**

# Application for Family or Medical Leave

Employee's Name: \_\_\_\_\_

Department: \_\_\_\_\_

Current Address: \_\_\_\_\_

Start Date of Anticipated Leave: \_\_\_\_\_

Expected Date of Return to Work: \_\_\_\_\_

Reason for Leave (Explain): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note:** A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician. I hereby authorize [the company] to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.  
I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by [the company].

Employee's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPROVED BY:**

Supervisor: \_\_\_\_\_

Human Resources: \_\_\_\_\_