FORM 620-3
APPLICATION FOR FAMILY OR MEDICAL LEAVE

Please complete the information below and submit to your school/department administrator for approval. Within 1 to 2 business days you shall receive an initial response.

Name: _____ School: _____

Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (Explain): _____

_____

_____

_____

NOTE: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician within 15 days of application for leave.

I hereby authorize a health care provider representing Region One to contact my physician to verify the reason for 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 Region One.

_____ _____

Employee Signature Date

APPROVED BY:

_____ _____

Administrator Signature Date