City of Gloucester
Request for Leave of Absence with or without Pay

Name (print)_____ Address _____ City, State, Zip _____ Telephone _____	Department _____ Direct Supervisor _____ Department Manager _____

PLEASE CHECK TYPE OF LEAVE REQUESTED: □ Initial request for leave □ Extension of leave

INDICATE PURPOSE OF LEAVE (may include multiple types of leave):

☐ FMLA

- □ For the birth and care of the newborn child of the employee*****
- □ For the placement with the employee of a child for adoption or foster care
- □ For serious illness or health condition that prevents the employee from performing the essential functions(s) of his or her job*****
- □ To care for a close family member or similar person with a serious illness or health condition*****

□ **MILITARY LEAVE**

- □ Military Exigency
- □ Military Caregiver

□ OTHER LEAVE

□ Unpaid Personal Leave □ Administrative Leave □ Military Leave □ Other _____

***Certification of Health Care Provider required**

□ Full time leave Hrs

Start Date _____
Expected End Date _____
_____

□ Intermittent Leave

Start Date _____ End Date _____
Start Date _____ End Date _____

Start Date _____ End Date _____

□ Intermittent/Alternate

Work Schedule Requested

I understand that the leave, if approved, may be used only for the purpose indicated above and the use of the leave for any other purpose may result in termination of the leave and/or may be grounds for disciplinary action. ***I have read the City's Leave of Absence Policy and understand that I am expected to return to work on the date indicated above.***

I further understand that a request for an extension of an approved leave of absence is subject to review and, if appropriate, further certification by the health care provider. I also understand that changes in the approved leave of absence period must be communicated to my supervisor and to the Human Resources Department.

Signature _____ *Date* _____

Department Manager Review *

□ I received notification of the above request on ___/___/___ and I recommend approval of the leave
□ I received notification of the above request on ___/___/___ and I recommend approval of the leave as modified herein:
_____
□ I received notification of the above request on ___/___/___ and I do not recommend approval of this leave for the following reasons:
_____

_____ _____
_____

Department Manager (print) Department Manager signature Date

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For Human Resources Use Only

Received on ___/___/___

□ This leave (or portion of leave) request is being designated as FMLA leave as of ___/___/___ to ___/___/___

□ This leave (or portion of leave) request is <u>not</u> being designated as FMLA leave as of ___/___/___ to ___/___/___

□ Full time Leave □ Intermittent Leave

Sick Hours Available _____ Vacation Hours Available _____

Human Resources Director Review

Received on ___/___/___

□ Approved
□ Approved as modified herein
_____
□ Denied for the following reasons
_____

_____

Signature _____ Date _____
Human Resources Director

INSTRUCTIONS

EMPLOYEE

1. Complete the top section of this form by selecting the type of request (initial or extended)
2. Indicate the purpose of the leave. The Certification of Health Care Provider should be sent directly to the HR Department.
3. Indicate if the leave is full time or intermittent and select start date(s) and return date(s) or alternative hours requested. If necessary, the return date can be modified subsequently to reflect an earlier or a later return. Requests to change the return date must be made to your Department Manager and to the HR Department.
4. Once you have completed, sign and date the top portion of the form, forward it to your Department Manager for review.
5. If your Department Manager recommends approval of the request, submit the form and any supporting document(s) (e.g., Certification of Health Care Provider) to the HR Department for further review and submission to Administration.
6. If your Department Manager does not recommend approval of the request, you may appeal to the CAO by submitting the form and any supporting document(s) for her review. The Certification of Health Care Provider should be sent directly to the HR department.

DEPARTMENT MANAGER

1. Indicate the date on which notification of leave request was made. After receiving and reviewing the request form, indicate your recommendation by checking the applicable box and then signing the request form. Signature designates receipt of form only, final approval will be determined by the HR Director.
2. Return the request form to the employee for submittal to the HR Department.

HUMAN RESOURCES

1. The HR Department will provide the employee with a copy of the request form(s) indicating the Administration's decision and will communicate the decision to the Department Manager.