REQUEST FOR LEAVE OF ABSENCE

Employee Section

Employee Name: _____ Employee Number: _____

Department: _____

Type of Leave Requested: (Check all that apply)

☐ Medical* ☐ Personal ☐ Educational ☐ Military

☐ Family & Medical Leave ☐ Worker's Compensation* ☐ Other

**Considered as FMLA up to the f rst twelve weeks of the leave if eligibility requirements /qualif cations are met. Family and Medical Leave (FMLA) runs concurrent with medical/worker's compensation leaves of absence.*

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you **not** provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Reason for Leave: _____

☐ Continuous Leave ☐ Intermittent Leave

Date leave is requested to begin: _____

Expected return to work date (if unknown, "pending medical certification"): _____

I understand that if this leave is a personal leave or a leave granted under the provisions of the Family and Medical Leave Act, any sick, vacation or holiday hours I am eligible to take and have available will be utilized from the start of the leave until the hours have been depleted, unless otherwise stated in my union contract or policies and procedures. I also understand that if my leave has been granted under the provisions of the Family and Medical LeaveAct and I do not return to work, I am obligated to repay Kent County the entire cost of the health care premiums for the period of the unpaid leave and/or have the amount owed deducted from my last pay check or any monies received from the County

I also understand if this leave request is approved, I must return to employment at the expiration of the leave of absence, unless I have made prior arrangements to have the leave extended, or my employment will be terminated.

Employee Signature: _____Date: _____

Department Section

This leave of absence request is: ☐ Approved ☐ Denied

Leave will begin: _____ Expected return to work date: _____

If unknown, "pending medical certification"

Employee ☐ has ☐ has no re-employment rights.

Remarks: _____

_____

Department Director/Judiciary or Designee:_____ Date: _____

HR Section

LOA

Human Resources Director/Designee:_____ Date: _____

FMLA

Family and Medical Leave Act (FMLA) ☐ Approved ☐ Denied ☐ N/A

HR Director/Designee Initials: _____ Copy to employee: _____