CITY OF WORCESTER

Request for a Leave of Absence

Directions for applying for a leave:

- Complete this form and return it to the designated person in your Department
- Health Care Provider completes: ***Certification of Health Care Provider (return to Human Resources Dept.)***

Employee's Name:	Complete Home Address:	
Department & Position held:	Day phone #:	Employee #:

REASONS FOR LEAVE (CHECK ONE):

Family and Medical Leave (FMLA)

- ❑ Birth of child Due Date: (Requires Certificate of Health Care Provider Form)
- ❑ Placement for Adoption/Foster Care (Requires placement documentation)
- ❑ Serious Health Condition of Employee (Requires Certification of Health Care Provider Form)
- ❑ Care for seriously ill family member (Requires Certification of Health Care Provider Form)

(If checked, provide name of seriously ill family member and relationship)

Name: Relationship:

Leave of Absence

- ❑ Medical (employees not eligible for FMLA)
- ❑ Military
- ❑ Maternity (employees not eligible for FMLA)
- ❑ Personal
- ❑ Small Necessities Leave: I certify that I will take _____ hours for: Medical reason for _____ child/ _____elderly relative

  Education reason for _____

Provide a brief statement on the reason for the leave requested:

Start Date: End Date:

❖ Are you requesting intermittent leave? YES NO (circle one)

Please explain:

❖ Are you requesting a reduced work schedule? YES NO (circle one)

I elect to use also the following eligible accumulated leave (subject to approval under FMLA):

☐ Vacation ☐ Sick time (only for personal illness) ☐ Personal Time ☐ I do not qualify for paid leave

I understand that if I fail to return to work as of the expiration date of my leave of absence, without an authorized extension from Human Resources, it will be understood that I have resigned employment from the City of Worcester (subject to ADA regulations). I also acknowledge that I have received a notice regarding Family Medical Leave (FMLA) if applicable.

Employee Signature:	Date:

A replacement for this employee ☐ will ☐ will not be required.

Department Head Signature:	☐ approved ☐ denied Date:
Director of Human Resources:	☐ approved ☐ denied Date:

Please note this request is subject to the final approval of the Director of Human Resources.

Print Form