Request for Leave or Approved Absence

1. Name: (Last, first, middle)	2. Employee Social Security Number

3. Organization:

Antelope Memorial Hospital/AMH Family Practice

4. Type of Leave of Absence

Check appropriate box(es) and enter date and time below

	Date From	Date To	Time From	Time To	Total Hours
☐ Accured Leave					
☐ Restored Leave					
☐ Accured Paid Days Off					
☐ Advanced Paid Days Off					

Purpose:
- ☐ Illness/Injury/Incapacitation of requesting employee
- ☐ Care of family member with a serious health condition
- ☐ Military Leave
- ☐ Other

- ☐ Compensatory time off
- ☐ Other paid absence *(specify in remarks)*
- ☐ Leave without pay

5. Family and Medical Leave

If annual leave, sick leave, or leave without pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please provide the following information:

☐ **I hereby invoke my entitlement to family and medical leave for:**
- ☐ Birth/Adoption/Foster care
- ☐ Serious health condition of self
- ☐ Serious health condition of spouse, son, daughter, or parent

Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the FMLA. Medical certification of a serious health condition may be required by your employer.

6. Remarks

7. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.

8. Employee Signature	9. Date Signed

10. Official Action on Request, (Give Reason for Disapproval)

☐ **Approved**
☐ **Disapproved**

11. Employer Signature	**12 Date Signed**

Privacy Act Statement

Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.

Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security number or tax identification number. This is an amendment to title 31, Section 7701. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.