Community Action Team, Inc

Employee Leave Request Form
(Please complete this form every time you use any paid or unpaid leave)

Employee Name:_____ Today's Date_____

I request 1 day or less:_____ _____am to _____pm
Date Time
I request more than 1 day:_____ _____
Date Hours Begin Date_____Return Date_____
Total number of hours taken:_____
I request that my leave be charged to: ___Sick Leave ____Personal Leave ____Unpaid leave

If OFLA/FMLA or Oregon Sick leave, please complete this section. Otherwise, you may proceed to signature line at bottom of page. Please check one of the following:
____Your serious health condition, certification may be required
____Family member with serious health condition Designate type of family member _____
____Child requiring home care, non-serious health condition
____Pregnancy, includes pre-natal care, child birth and recovery
____Care for a newborn child, placement/adoption/foster child
____Bereavement Leave
____Domestic Violence, Sexual Assault, Stalking
____Yours or family member non-serious health condition Designate type of family member_____
____Routine Medical/Dental Visits for yourself or family member

Note: In some instances it may be necessary for your Supervisor or Human Resource Director to ask for additional information to determine whether this leave is OFLA/FMLA or Oregon Sick Leave qualifying.

If you are requesting an altered or reduced work schedule for medical reasons, either for yourself or family members, please indicate your scheduling needs: (Attach a separate sheet if necessary)

Employee's Signature:_____

Confidentiality: Any medical information will be kept in a confidential file and will be used only to determine eligibility for OFLA/FMLA, Oregon Sick Leave and Disability and to track the leave.

_____Personal/Unpaid Leave Approved _____ Personal/Unpaid Leave Not Approved

_____
Supervisor's Signature Date

For Human Resource Use Only

Leave Designation: _____OFLA _____FMLA _____Both _____ Oregon Sick Leave

Provisional Leave Designation (pending additional information or medical certification):

_____OFLA _____FMLA _____Both _____Oregon Sick Leave

Date employee notified:_____