Granville County

REQUEST FOR FMLA and OTHER LEAVES OF ABSENCE

A. EMPLOYEE SECTION: The employee must complete this form and attach appropriate documentation for the type of leave requested.

Name: ________________________________ Department: ________________________________

Address: ________________________________ Job Assignment: ________________________________

________________________________ Phone Number: ________________________________

B. LEAVE PERIOD: Enter the period of time you are requesting to be away from work.

I am requesting a leave of absence from________________________to______________________.

C. TYPE OF LEAVE REQUESTED

FMLA

☐ A serious health condition of self or birth of a child *(Form WH-380-E required)* ☐ Intermittent

☐ A serious health condition immediate family member *(Form WH-380-F required)* ☐ Intermittent

☐ Adoption/placement of a child *(legal documents required)* ☐ Intermittent

Other Leave

☐ **Medical** (medical documentation is required) ☐ **Military** (documentation is required)

☐ **Leave without pay** *(provide explanation)*____

☐ **Other leave** *(provide explanation)*____

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D. REQUEST FOR VOLUNTARY SHARED LEAVE

A special request can be made for the donation of Voluntary Shared Leave (VSL) if the employee is on approved FMLA leave and has exhausted all of his/her accrued leave before the expiration of the FMLA.

I, ________________________________, hereby permit Human Resources to make a request on my behalf for donated leave without sharing my name as part of the request unless I have provided a signed release allowing my name to be released.* I understand that I must exhaust all my earned leave prior to receiving any donated leave. I further understand that voluntary shared leave can only be used while on an approved FMLA leave certified by a medical provider and that any unused leave will be returned to the donor at the end of my FMLA leave.

*Contact human resources for a copy of the written release form.

____ ______________________

Employee Signature for Voluntary Shared Leave Request Date

E. ACKNOWLEDGEMENT: All requests must be acknowledged and signed in the space below.

My signature below certifies that I understand if I go into a leave without pay status, I can continue my health insurance through COBRA and I will be responsible for all other miscellaneous payroll deductions (dental, life and supplemental insurances, loan payments, etc.) and that it is my responsibility to make arrangements with the finance department to maintain coverage. I also understand that my request for FMLA, if approved, will count against my 12 weeks of FMLA entitlement and that I must provide human resources a "Return to Certification" statement from my physician prior to my return to work.

____ ____

Employee's Signature Date Department Head/Supervisor Signature Date

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Human Resource Director Date County Manager Signature (if needed) Date