**Evolve Intervention Request for Leave of Absence Form**

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| **Section 1: PERSONAL INFORMATION (Staff Member completes Sections 1 and 2 and returns completed form to Supervisor/Manager)** | | | | |
| **Last Name:** | | **First Name:** | | **Job Title:** |
| **Home Phone:** | | **Email:** | | **Line Manager:** |
| **Date Submitted:** | | **Signature:** | | |
|  | | | | |
| **Section 2: STAFF MEMBER: Check the type of leave and provide documentation as indicated** | | | | |
| **I request that my leave begin on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and end on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (If necessary, give approximate dates.)** | | | | |
| **Family Medical Leaves (required medical certifications must be returned within 15 days of receipt)** | | | | |
| **Category of Request** | | **Supporting Documentation to be submitted** | | |
| **□** | **Employee Illness** | **Written evidence from Healthcare Provider** | | |
| **□** | **Child/Parent/Spouse Illness** | **Written evidence from Healthcare Provider** | | |
| **□** | **Maternity** | **Certificate of Health Care Provider** | | |
| **□** | **Paternity** *(Must be taken within one year of birth)* | **Certificate of Health Care Provider** | | |
| **□** | **Adoption/Placement of Foster Child**  *(Must be taken within one year of placement)* | **Letter of Placement** | | |
| **□** | **Military Caregiver** | **Certification for Serious Illness or Injury of Covered Service Member** | | |
| **□** | **Military Exigency** | **Certification of Qualifying Exigency** | | |
| **Personal Leaves (not FMLA eligible or not FMLA related)** | | | | |
| **□** | **Educational** | **Letter of Acceptance from Educational Institution** | | |
| **□** | **Medical (non-FMLA)**  *(Only available for staff member’s own illness/injury)* | **Certification from Health Care Provider** | | |
| **□** | **Military (non-FMLA)** | **Department of Defense Orders confirmation** | | |
| **□** | **Maternity (not eligible for FMLA)** | **Certification from Health Care Provider** *(including expected delivery date)* | | |
| **□** | **Paid Parental Leave** *(May run concurrently with FMLA)* | **Primary Caregiver statement** | | |
| **□** | **Other Personal** *(e.g. compassionate leave)* | **Explanation of Request** | | |
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| **Section 3: SUPERVISOR/MANAGER/DEPARTMENT HR: Complete this section** | | | | |
| **Name (Print):** | | | **E-mail:** | |
| **Signature:** | | **Phone:** | | **Date:** |
| **Name(s) and E-mail(s) of any others to receive copy of determination:** | | | | |
| **If this leave is for a Family Medical Leave:**   1. Has Staff Member had absences counted towards FMLA entitlement in the past 12 months? **□ YES □ NO**   If so, provide dates/hours which have already been applied towards FMLA, along with supporting documentation  Dates: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total hours of FMLA utilized during the past 12 months: \_\_\_\_\_\_\_   1. If approved, will this leave be taken on an intermittent basis? **□ YES □ NO**   *(Not available for adoption, placement in foster care or Paternity leave; only available for maternity leave if medically necessary)* | | | | |
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| **Section 4: DETERMINATION BY DIRECTOR** | | | | |
| **Leave dates have / have not been approved** | | | | |
| **Leave dates approved From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Signed:** | | | **Date:** | |
| **Name: Emma Prince** | | | **Role: Director** | |