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

|  |
| --- |
| **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**  |
|  |
| **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 documentationDates: 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)*  |
|  |
| **Section 4: DETERMINATION BY DIRECTOR** |
| **Leave dates have / have not been approved** |
| **Leave dates approved From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Signed:** | **Date:** |
| **Name: Emma Prince** | **Role: Director** |