WASHINGTON COLLEGE

FIRST COLLEGE CHARTERED IN THE NEW NATION

Request for Family or Medical Leave

Name: _____Department: _____

Address: _____

Phone: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (Explain): _____

_____

_____

_____

_____

_____

_____

NOTE: An employee requesting leave for the employee's own serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician within 15 days of submitting this request for leave.

_____ _____

Signature Date

APPROVED BY:

_____

Supervisor

_____

Director of Human Resources