



**DEPARTMENT OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION**  
**EMPLOYEE LEAVE APPLICATION**

Please print

Employee Last Name	First Name	MI
Employee Home Address		
Employee Social Security Number	Position number / Facility	
Home Telephone Number	Work Telephone Number	

**I. Reason For Leave**

<input type="checkbox"/> Family Leave*	<input type="checkbox"/> Maternity Leave	
<input type="checkbox"/> Medical Leave	<input type="checkbox"/> Educational Leave	
<input type="checkbox"/> Military Leave	<input type="checkbox"/> Personal Leave	* <input type="checkbox"/> Spouse
<input type="checkbox"/> Workers Comp Leave		<input type="checkbox"/> Parent
		<input type="checkbox"/> Child

**II. Expected Length of Leave**

Expected (or Actual) Date for Leave to Begin:

Anticipated Date for Return:

**III. Leave Coverage**

Indicate the number of days that you wish to have your accrued, unused annual leave used \_\_\_\_\_ # of days or \_\_\_\_\_ all available.

Indicate the number of days that you wish to have your accrued, unused bonus leave used \_\_\_\_\_ # of days or \_\_\_\_\_ all available.

Indicate the number of days that you wish to have your accrued, unused sick leave used \_\_\_\_\_ # of days or \_\_\_\_\_ all available.

**IV. Acknowledgement**

I have reviewed the materials contained in this Leave Kit and understand my eligibility for leave. I understand and acknowledge the following:

1. If eligible, my position or equivalent position is protected for up to 12 weeks under Family and Medical Leave or for 52 weeks during a five-year period under Family Illness Leave.
2. If my leave extends beyond the expected return date, I will provide additional documentation as requested.
3. If eligible, any FML or FIL leave will run concurrently with any sick leave or annual leave used.

Employee Signature	Date
Supervisor Signature	Date
Human Resources Representative	Date