DEPARTMENT OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION

REQUEST AND APPROVAL FOR LEAVE WITHOUT PAY

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

____ Family Leave*
____ Medical Leave
____ Military Leave
____ Workers Comp Leave

____Maternity Leave
____Educational Leave
____Personal Leave

*____Spouse
____Parent
____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 discussed my eligibility for leave with a Human Resources Representative. I understand and acknowledge the following:

1. If eligible, my position or equivalent position is protected for up to 12 weeks under the Family and Medical Leave Act.
2. If my leave extends beyond the expected return date, I will provide additional documentation as requested.
3. If eligible, any FMLA leave will run concurrently with any sick leave or annual leave used.

Employee Signature	Date
Supervisor Signature	Date
Human Resources Representative	Date