REQUEST FOR EXTENDED MEDICAL LEAVE
or LEAVE WITHOUT PAY (LWOP)
NOTE: EXTENDED MEDICAL LEAVE OR LWOP WILL NOT BE GRANTED FOR PERIODS EXCEEDING ONE YEAR

Employee Name:	Employee ID:	
Beginning Date:	End Date:	

TO BE COMPLETED BY EMPLOYEE

Reason for Leave Request (attach additional sheet if necessary):

_____ _____

Employee Signature Date

NOTE: If request is due to medical reasons, employee's signature constitutes a release granting the right to contact the employee's physician regarding the condition(s) relative to the request.

TO BE COMPLETED BY MEDICAL DOCTOR OR HEALTH CARE PROFESSIONAL

Please describe the **nature, severity** and **anticipated duration** of the medical condition (attach additional sheet if necessary):

Physician's Address

Physician's Telephone Number: ( )	Physician's Signature	Date

APPROVALS:

		Approved	Disapproved
_____ Immediate Supervisor	_____ Date	☐	☐
_____ Deputy Director (Required for leave requests of 30calendar days or less)	_____ Date	☐	☐
_____ Executive Director (Required for leave requests of 31 days to one year)	_____ Date	☐	☐