CHICO STATE ENTERPRISES

REQUEST FOR LEAVE OF ABSENCE

Section 1: PERSONAL INFORMATION (Employee completes Sections 1 and 2. Submit completed form to Supervisor/Manager)

Last Name:	**First Name:**	**Employee ID:**
Home Address:	**Phone (Primary):**	**Department/Manager:**
City, State:	**Personal Email:**	**Job Title:**
Signature:	**Date Submitted:**	**Original Hire Date:**

Section 2: EMPLOYEE REQUEST (Complete the required information in writing, check leave type and provide attachments as required)

I request that my leave begin on _____ and end on _____. (If necessary, give approximate dates.)

Leave includes _____ work days missed, excluding _____ holidays.

Total Personal Days accrued and to be used during leave _____. [Includes _____Sick Days and/or ____Vacation Days, if accrual is not combined PTO]

Family and Medical Leave (medical certifications are REQUIRED as listed for each Leave Request and must be submitted within 15 days of receipt)

☐	**Employee Illness**	**Certificate of Health Care Provider**
☐	**Child/Parent/Spouse Illness**	**Certificate of Health Care Provider for Family Member's Illness/Injury**
☐	**Maternity**	**Certificate of Health Care Provider**
☐	**Bonding**	**Certificate of Health Care Provider (Must be taken within one year of birth)**
☐	**Adoption/Placement of Foster Child**	**Letter of Placement (Must be taken within one year of placement)**
☐	**Military Caregiver**	**Certification for Serious Illness or Injury of Covered Service Member**
☐	**Military Exigency**	**Certification of Qualifying Exigency**
☐	**Other State Specific Leave _____**	**Certified documentation relevant to state specific leave request**

Personal Leaves (not FMLA eligible or not FMLA related) – Please check all that apply.

☐	**Medical (non-FMLA)**	**Certificate of Health Care Provider**
☐	**Military (non-FMLA)**	**Department of Defense Orders**
☐	**Maternity (not eligible for FMLA), including Paid Parental Leave**	**Certificate of Health Care Provider Primary Caregiver Affidavit for Paid Parental Leave**
☐	**Paid Parental Leave (non-maternity)**	**Certificate of Health Care Provider Primary Caregiver Affidavit for Paid Parental Leave**
☐	**Bereavement**	**Applicable documentation as may be listed in policy.**
☐	**Jury Duty**	**Summons, and applicable documentation as may be listed in policy.**
☐	**Other Personal (Victim, Witness, _____)**	**Describe:**
☐	**Other State Specific Leave _____**	**Describe:**

Section 3: SUPERVISOR/MANAGER (route to HR for Approval): Complete this section

Authorizing Name (Print):	**Email:**	
Signature:	**Phone:**	**Date:**
Name(s) and email(s) of any others to receive Determination Form:		
Approving HR Name (Print):	**Email:**	

(1) Has employee had absences counted towards FMLA entitlement in the past 12 months? ☐ **YES** ☐ **NO**
Provide dates/hours which have already been applied towards FMLA, along with supporting documentation

Dates: From _____ to _____ Total hours of FMLA utilized to date: _____

(2) If approved, will this leave be taken on an intermittent basis? ☐ **YES** ☐ **NO**

(3) Leave dates approved by HR Determination Form From _____ To _____ Notification Date: _____ By:_____