

DIOCESE OF BATON ROUGE
EMPLOYEE REQUEST FOR FAMILY AND/OR MEDICAL LEAVE

SECTION 1: For Completion by the EMPLOYEE	
Employee Name:	
Employee Home Address:	
Home Phone Number:	Work Phone Number
Cell Phone Number:	Email:
Parish/School/Office:	
Work Address:	
Reason for Leave (Check all applicable):	
<input type="checkbox"/> Employee's Own Serious Health Condition (may require medical certification)	
<input type="checkbox"/> Birth/Adoption/Pre-Adoptive Foster Care	
<input type="checkbox"/> Foster Placement	
<input type="checkbox"/> To Care for Family Member or Military Service member with Serious Health Condition * (may require medical certification)	
<input type="checkbox"/> For a Qualifying Exigency due to the military active duty status or call to active duty status of a spouse, son or daughter or parent (certification may be required)	
<i>* When Family and Medical Leave is needed to care for a family member or servicemember, you must state the care you will provide and an estimate of the time period during which this care will be provided, including a schedule of intermittent leave or leave on a reduced work schedule, if requested.</i>	
Anticipated Begin Date of Leave:	Anticipated End Date of Leave:
Briefly Explain Reason for Leave (if leave is to care for someone, please indicate name of and relationship to the person who needs care)	
Substitution Of Paid Leave: Please indicate if you would like to use paid leave during your absence and how many hours you plan to use (to the extent provided by law).	
<input type="checkbox"/> Vacation (_____ Hours)	<input type="checkbox"/> Sick Leave (_____ Hours)
I authorize the appointing authority to obtain any necessary information regarding my request for family and medical leave.	
Employee Signature: _____ Date: _____	
Section 2: For Completion by the EMPLOYER	
Leave Request is:	
<input type="checkbox"/> Approved	
<input type="checkbox"/> Not approved (explain on back side of form)	
Authorizing Signature: _____ Date: _____	