COUNCIL FOR THE SPANISH SPEAKING, INC.
FAMILY OR MEDICAL LEAVE REQUEST FORM

Name: _____ Social Security Number: _____

Home Address: _____ Department: _____

_____

_____
City State Zip

Home Telephone Number: _____ Work Telephone Number: _____

DATES OF LEAVE REQUESTED: From: _____ To: _____

REASON FOR LEAVE:

☐ The birth of my son or daughter and to care for such child

Actual or expected date of birth: _____

☐ The placement of a son or daughter with me for adoption or foster care

Actual or expected date of placement: _____

☐ To care for my spouse, son, daughter, or parent (circle one) who has a serious health condition (Physician's or practitioner's certification may be required)

☐ My own serious health condition (Physician's or practitioner's certification may be required)

Explain the need for the leave. (Describe the intermittent leave schedule if requesting a reduced schedule.):

_____

_____

SUBSTITUTION OF PAID LEAVE:

☐ Vacation _____ Hours

☐ Personal/Floating Holiday _____ Hours

☐ Sick Leave _____ Hours

☐ Other (specify) _____ Hours

I certify that the above information is accurate and complete. I authorize the appointing authority to obtain any necessary information regarding my request for family or medical leave.

EMPLOYEE SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY: Leave request is:

☐ APPROVED

☐ NOT APPROVED (Explanation on reverse side)

Approved leave will qualify under FMLA/WFMLA or other leave provisions to the extent that the employee meets the requirements for eligibility.

_____
Supervisor Date

_____
President/CEO Date

Distribution: Employee, Employee's Supervisor, Employee's Personnel File