APPLICATION FOR FAMILY OR MEDICAL LEAVE

A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a verifying medical certification from a physician on the Certification of Health Provider form.

Name: _____ Program: _____

Current Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason Leave (Explain): _____

_____

_____

_____

I hereby authorize SOCO to contact my physician to verify the reason for my requested leave or for any other information concerning my requested family and medical leave.

I understand when FMLA Leave is based on my own serious health condition, I will be required to submit a return-to-work certification from my physician before being allowed to return to work.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by SOCO.

I understand that I will be required to reimburse SOCO for my health insurance premiums should I not return to work for reasons other than those approved by the FML Act.

Signature:_____ Date:_____

APPROVED BY:

_____

Program Director Date

_____

Executive Director Date