City of Revere Leave of Absence Request Form

Please read before using this form:

Please be aware that further documentation may be required in addition to this form before your request for leave can be approved. Any employee requesting a leave of absence should follow guidance from the Human Resources Department regarding the use of this form and sources of additional documentation.

Employee Name:	
Employee Address:	
Telephone Number:	
Date:	

I hereby request:

☐ A leave of absence ☐ An extension of my current leave of absence

Leave begin date:	
Estimated end date:	
Estimated return to work:	

The reason for my request for a leave of absence or request for an extension is as follows (check off one):

1. ☐ **Military Leave**

2. ☐ **Personal Leave**

3. **Medical Leave** (select one of the following):

   ☐ Pregnancy disability
   ☐ Work-related injury or illness
   ☐ FMLA: Non-work and non-pregnancy disability

4. **Family Medical Leave** (select one of the following): ☐ Intermittent ☐ Continuous ☐ Reduced Schd

   ☐ Birth, adoption, or placement of a child
   ☐ Serious health condition affecting spouse, child or parent
   ☐ Care of an injured or ill service member
   ☐ Family member's call to active duty

Note that all requests for medical leave must include a statement of medical necessity from the affected person's doctor.

The following is a description of the reasons for my request for leave or an extension of leave (disregard this section if you are requesting a medical leave for yourself):

Describe reason for leave or extension of leave:

1. I understand that if my application for Short Term Disability is approved, any paid medical or pregnancy disability leave taken that qualifies as leave under state and/or federal family/medical acts will be counted as family/medical leave and charged to my entitlement of twelve (12) work weeks of family/medical leave in a twelve (12) month period.
2. I understand that if I am eligible to make changes to my City benefits, I must make the changes within 31 calendar days from the qualified event date or understand that I must wait until the next Open Enrollment period.
3. I understand that if I am requesting medical leave or family leave, I must submit the Certification of Health Care Provider form as soon as practical under the circumstances and any time off granted will be counted against my twelve (12) week leave entitlement under the Family and Medical Leave Acts, if applicable.
4. I understand and agree that I must return to work or timely request and be granted an extension of my leave by the date specified above or my employment may be terminated.
5. I understand and agree that City has the right to deduct any overpayment of wages paid to me during my leave upon my return to active employment. I further agree that if my employment is terminated for any reason without having satisfied my overpayment that City has the right to deduct the balance from my final pay or seek direct payment from me.

I HAVE READ THIS ENTIRE DOCUMENT BEFORE SIGNING.

Employee's Signature:		Date:	
Department Head Signature:		Date:	
Mayor's Signature: **(Required for personal leave)**		Date:	
Human Resources Signature:		Date:	

Note that all requests for medical leave must include a statement of medical necessity from the affected person's doctor.