REQUEST FOR MEDICAL LEAVE OF ABSENCE

Name _____ SSN _____ PIN Number _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

Job Title _____ Department _____ Location _____

Supervisor's Name _____ Supervisor's Phone _____

Last Day Worked _____

Date of Leave: From _____ Anticipated Date of Return _____

Original Request □ Extension □

MEDICAL LEAVE – *Covered under Family/Medical Leave Act*

This leave is for illness or injury. Your request will be considered for approval upon the receipt of **both** of the following forms

Request for Medical Leave of Absence : completed and submitted to **your manager** by the seventh (7th) day of absence.

Medical Status Report Form : completed by the treating physician, explaining your absence from work, and faxed to Medical Services at (708-332-4349) within seven (7) days of the first day of absence.

You will be granted a specified length of time for your medical leave, by Medical Services. If you need an extension to that time, you must submit another ***Medical Status Report*** form, completed by your doctor, to Medical Services within 3 days of the expiration of your leave in order to be granted an extension.

Continuation of your medical leave **requires** that all medical information be submitted as requested. **FAILURE TO PROVIDE CONTINUING DOCUMENTATION WILL RESULT IN DELAY AND/OR TERMINATION OF YOUR MEDICAL LEAVE.**

When returning from a medical leave, you must provide a *Medical Status Report* form signed by the treating PHYSICIAN, which will be reviewed and approved by Medical Services and/or Medical Consultant before returning to work. Medical forms are available from Medical Services and your department.

I have read this form in its entirety and understand what I have read. To my knowledge, the information I have provided is correct and truthful.

Employee's signature: _____ *Date:* _____

Supervisor's signature: _____ *Date:* _____

Medical Services

This medial leave is approved from _____ *to* _____.

Medical Services Signature: _____ *Date :* _____

BEFORE EMPLOYEE RESUMES WORKING HE/SHE MUST:

Supply release from private physician □ **Take return to work drug screen** □ **Take return to work physical** □