APPLICATION FOR FAMILY OR MEDICAL LEAVE

Name: ____________________________

Current address: _________________________________

Position: _______________________________

School or Worksite: ____

Beginning date of leave: ____

Expected date of return to work: ____

Reason for leave request (explain): ____
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If family leave to care for a seriously ill family member is requested, state:

1. Name of Family Member: _____________________________________
2. Relationship of family member to you: ____
3. Describe care you will provide: ____

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Name and Mailing Address of Health Care Provider(s): ____
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