



Request for Leave of Absence (LOA)

PLEASE COMPLETE AND RETURN THIS FORM 30 DAYS IN ADVANCE OF LEAVE IF POSSIBLE

EMPLOYEE INFORMATION			
Employee Name (First, Middle Initial, Last)			Employee ID #
Home Address	City	State	Zip
Job Title/ Department	Telephone Number <input type="checkbox"/> HOME <input type="checkbox"/> CELL		

ABSENCE INFORMATION	
Within any twelve month period, no more than two (2) occurrence of LOA may be approved. Employees may not exceed the cumulative total of six (6) weeks. A leave may not be requested on an intermittent basis.	
Requested Start Date:	Anticipated Return Date:
Number of Weeks Approved in the last 12 Months:	Date of Last LOA Request:

REASON(S) FOR LEAVE OF ABSENCE		
<input type="checkbox"/> MEDICAL	<input type="checkbox"/> PERSONAL	<input type="checkbox"/> EDUCATION
<input type="checkbox"/> MATERNITY/PATERNITY	<input type="checkbox"/> FAMILY ILLNESS	<input type="checkbox"/> OTHER _____

If leave request is medically related, a medical certification form must be returned to human resources. All "other" requests must be approved by the County Manager or his designee.

PAID LEAVE AVAILABLE			
A leave of absence may consist of leave without pay and/or paid leave. I request to use the following leave categories:			
Type	Number of Hours	Dates: From	Through
Sick Leave	_____	_____	_____
Vacation	_____	_____	_____
Leave w/o Pay	_____	_____	_____
Shared Leave	_____	_____	_____

PROCESSING INSTRUCTIONS	
<input type="checkbox"/>	Employee requests supervisor approval if leave is a non-medical request.
<input type="checkbox"/>	If leave request is medically related, leave request is returned to human resources with completed medical certification attached. Medical request do not need supervisor approval.
<input type="checkbox"/>	Employee is required to pay 100% of the premium rates for health, dental and life insurance benefits including any portion that Forsyth County now pays on an employees' behalf) for any pay period in which no hours worked or paid.
<input type="checkbox"/>	If unpaid leave, attach a status report to this form and return to the Human Resources Department.
<input type="checkbox"/>	The Human Resources Department notifies employee of decision.

Employee Signature:	Date:
Supervisor Signature: (If applicable)	Date:
Department Director Signature: (If applicable)	Date:

DECISION	
Human Resources Representative Signature:	<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED