

Leave of Absence Request Form

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to take up to 12 or 26 weeks of job-protected leave for certain family, medical, or military reasons. Submit this request form to the Talent Service Center at least 30 days before the leave is to begin. LRH reserves the right to deny or postpone leave requests if adequate notice is not given when permitted under federal and/or state law. Medical, Personal and Education leaves are granted at the discretion of the Talent Department. This form is required for ALL leaves. Failure to submit all required forms within 15 days of submitting this form could result in denial of your leave request. Please submit completed forms to TalentServices@myLRH.org or fax to 863-284-1829.

Employee's Full Name (Please print clearly) _____ Badge # _____

Leave Start Date _____ Leave Ending Date _____ Last Day Worked _____

SECTION I: Reason for requesting time off (Please check all that apply)

- A. MY SERIOUS HEALTH CONDITION *Employee Medical Certification required.
- B. CARE FOR A FAMILY MEMBER WITH SERIOUS HEALTH CONDITION: *Family Member Medical Certification required.
Name: _____ DOB: _____ Relationship to you: _____
- C. BIRTH OF A CHILD/CARE FOR A NEWBORN CHILD: Estimated Due Date: _____
 Pregnancy/Child Birth *no additional paperwork required. Paternal Leave *no additional paperwork required
- D. PLACEMENT OF A CHILD : To care for your adopted or foster child *Legal documents required.
- E. EDUCATION: *Class schedule/proof of enrollment required.
- F. MILITARY SERVICE OR SERVICE MEMBER FAMILY LEAVE *Military orders required.
- G. PERSONAL (non-medical): Reason for leave request _____
- H. FLORIDA DOMESTIC VIOLENCE LEAVE *Legal documents required. (All available ETO must be exhausted)

SECTION II: (Please check one to determine the type of leave needed)

- Continuous Leave – leave taken as one block of time
- Intermittent Leave – leave taken, as needed, over a period of time for medical or military reasons
- Reduced Schedule – leave taken as a reduced schedule for a medical reason

SECTION III: By signing below, you acknowledge you have notified your manager that you have requested a leave of absence. Approval is dependent on your eligibility for the type of leave requested and medical information/documentation provided. Final notification of leave of absence will be sent to your Lakeland Regional Health email and personal email from Talent Services.

Daytime Phone: _____ Employee Personal Email Address _____

Employee Sign: _____ Date: _____

Manager Name: _____ Manager Notified