Application for Family or Medical Leave

Name: _____ Department: _____

Current Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave (Explain): _____

_____

_____

_____

_____

NOTE: An employee requesting for the employee's serious health condition or the serious health condition of an employee's spouse, child, or parent must submit a verifying medical certification from a physician within 15 days of the Human Resources Office's receipt of the application for leave.

I hereby authorize a Human Resources Representative from the County of York to contact my physician to verify the reason for my requested family and medical leave.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the County of York.

Signature: _____ Date: _____

Acknowledged By:

_____

Department Head Date

Approved By:

_____

Authorized Human Resources Representative Date