# APPLICATION FOR FAMILY OR MEDICAL LEAVE

**EMPLOYEE NAME:** ________________________________ **DATE:** _____/_____/______

**DEPARTMENT:** ____________________________________

**CURRENT ADDRESS:** _______________________________________________________________

**START DATE OF ANTICIPATED LEAVE:** __________________________

**EXPECTED DATE OF RETURN TO WORK:** ________________________

**REASON FOR LEAVE (EXPLAIN):**

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

**NOTE**: An employee requesting leave for the employee's serious health condition, the serious health condition of the employee's spouse, child or parent or to care for a covered servicemember must submit a verifying medical certification from a physician within 15 days of application for leave.

I hereby authorize a health care provider representing the Town of Surfside to contact my physician to verify the reason of 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 Town of Surfside.

Employee signature: _______________________________ Date: _________________

Received by: _____________________________________ Date: _________________
Department Head

_____________________________________ Date: _________________
Human Resources