St. Clair County Community Mental Health

Request for Leave of Absence

MEMORANDUM

TO: _____, HR Labor/Employee Relations Manager

FROM: _____

DATE: _____

SUBJECT: **Request for Leave of Absence**

To be completed by employee/designee:

Type of leave requested:

☐ Educational ☐ Disability* ☐ FMLA* ☐ Other** _____

* Attach certification if available at time of request.
** Attach detailed reason of the need for leave.

Expected duration of leave:

From: _____ To: _____

Comments: _____
_____
_____

Will this leave be: ☐ Paid ☐ Unpaid

Will you be using any accrued time: ☐ Yes → ☐ Sick ☐ Vacation ☐ Overtime
☐ No

Any additional information: _____
_____
_____

Questions/Concerns: _____
_____
_____

If this leave is for the birth or adoption of a child, and if your spouse also works for this agency, is your spouse planning on taking any time off for this event? ☐ Yes ☐ No ☐ N/A

St. Clair County Community Mental Health Authority

Request for Leave of Absence

To be completed by HR Designee:

☐ Employee ineligible for leave (reason): _____

_____

_____

☐ Employee eligible for the following type of leave:

☐ Educational ☐ Disability ☐ FMLA

☐ Other: _____

Recommendation:

☐ Approve (why): _____

_____

_____

☐ Disapprove (why): _____

_____

_____

To be completed by Supervisor and/or Service Director:

Clarify how program coverage will be handled during the leave: _____

_____

_____

Questions/Concerns: _____

_____

_____

_____ _____

Supervisor Signature Date

To be completed by Human Resources Director/Designee:

☐ Approved as submitted

☐ Unable to process due to insufficient or inaccurate information as follows (explain): _____

_____

_____

_____ _____

Human Resources Director/Designee Signature Date

Cc: Personnel/Confidential File – Original
Supervisor
Chief Clinical Officer
HR Director
Staff Requesting Leave