

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 leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying medical certification from a physician within 15 days of application for leave.

I hereby authorize the City of Quincy 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 City of Quincy.

Signature: _____ Date: _____

APPROVED BY:

Supervisor

Director of Human Resources

Notice of Intention to Return From Leave

Name: _____

Supervisor: _____

Date leave commenced: _____

Date of planned return: _____

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee may be required to provide a written certification from his or her health care provider that the employee is able to resume working.
2. Every attempt will be made to restore an employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.
3. An employee returning from family or medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

Employee's signature

Date

I have examined (employee) and can certify that she/he is fully able to resume working.

Health care provider's signature

Date