WASHINGTON CONFERENCE of Seventh-day Adventists

Leave of Absence Form

Human Resources
32229 Weyerhaesuer Way S
Federal Way, WA 98001
Ph: (253) 681-6008
Fax: (253) 681-6009

Please review the Conference leave of absence policy, complete all applicable sections of this form, and send to Human Resources

1. Name _____

2. Date of Hire _____

3. Position _____
   Location _____
   Supervisor _____
   Cell Phone: _____
   Non-Work Email Address: _____

4. Type of leave requested:
   ☐ FMLA
   ☐ Medical (Non-FMLA)
   ☐ Pregnancy Disability
   ☐ Personal

5. Please indicate the reason(s) you are requesting leave (check appropriate boxes):

   ☐ Birth of my child
   Expected Delivery Date _____

   ☐ Adoption or placement of a child for foster care
   Child's Name _____
   Scheduled Date of Adoption or Placement
   _____

   ☐ To care for my ☐ child ☐ spouse ☐ parent who has a serious medical condition **(Healthcare provider Certification required)**
   Name of Child, Spouse or Parent _____

   ☐ My own serious health condition which makes me unable to perform my job duties **(Healthcare provider Certification required)**

   ☐ Because of a qualifying exigency arising out of the fact that my **(check one)** ☐ spouse ☐ son ☐ daughter or ☐ parent is on active duty or call to active duty status as a member of the regular or reserve Armed Forces **(Certification Required for First Request)**. Name of Covered Military Member:
   _____

   ☐ Because I am the **(check one)** ☐ spouse ☐ son ☐ daughter ☐ parent or ☐ next of kin of a covered service member with a serious injury or illness **(Medical Certification required)** Name of Covered Military Member:
   _____

6. I request leave from _____ to _____
   Start Date End Date

7. Are you requesting FMLA Leave on an intermittent or reduced leave schedule? **(Not permitted for birth, adoption or placement of child.)**
   ☐ Yes ☐ No
   Your health care provider must provide certification which justifies the medical necessity for intermittent or reduced leave schedule.

8. If the answer to **"7"** is **"Yes,"** please describe proposed intermittent/reduced work leave schedule.
   _____
   _____
   _____
   _____

9. Are you requesting leave due to a work-related injury or illness?
   ☐ Yes ☐ No

10. If the answer to "9" is yes, please indicate whether you elect to use your accrued sick pay or vacation to supplement your workers' compensation benefits?
    ☐ Yes ☐ No

I verify that I have read and understand this form and that the information I have provided is true, correct, and complete.

_____ _____
EMPLOYEE SIGNATURE **DATE**