CATHOLIC DIOCESE OF ROCKFORD
REQUEST FOR LEAVE OF ABSENCE

Employee: _____ Position: _____

Work Location: _____ City: _____

Supervisor's Name and Signature: _____

Last Day of Work _____ Anticipated Return to Work Date _____

Are you requesting a continuous block of time or intermittent time off: □ Continuous □ Intermittent

Type of Leave requested:

____ Family and Medical Leave (check below as applicable)
- ___ Employee's serious health condition
- _ __ Employee's pregnancy
- ___ Employee's spouse's pregnancy
- ___ Spouse's serious health condition
- ___ Parent's serious health condition
- ___ Dependent Child's serious health condition
- ___ Birth of Employee's child
- ___ Birth of a child by Employee's Spouse
- ___ Adoption of child by Employee, or Foster Care placement of Child with Employee
- ___ Leave for Qualifying Exigency regarding active military duty of parent, spouse, or child of Employee
- ___ Leave for Next of Kin Military Service Member Line-of-Duty Serious Illness/Injury

____ Family Bereavement Leave
- ___ death of immediate family member
- ___ event affecting Employee's parenthood

____ Bereavement Leave for Death of Employee's child by Homicide or Suicide
____ Leave for Domestic or Sexual Violence or Crime of Violence
____ Family Military Leave due to Employee's Spouse or Child called to active military duty
____ Military Leave of Employee
____ Jury Duty Leave
____ Blood and Organ Donation Leave
____ School Visitation Leave

I understand that if I am requesting leave due to a health condition or injury, I am required to provide to my employer medical verification and I agree to meet with the employer to discuss the requested and possible alternative accommodations (Refer to the applicable policy in the Employee Handbook.). I understand that to be eligible for an FMLA leave, I must have worked for the Diocese for the previous 12 consecutive months and worked at least 1,250 hours during that 12-month period, and the reason for the leave must be a reason that qualifies under the FMLA. I understand I will be notified by my employer whether this leave is approved. I also understand that I am required to provide periodic updates to my employer on the medical verification and the continued need for accommodation.

_____ _____

Employee Date

Approved by:

_____ _____

Supervisor's Signature Date