



Long Island Head Start REQUEST FOR LEAVE

EMPLOYEE'S NAME:	DATE:	
ADDRESS:	Status (check one) () Exempt () Non-Exempt () Full time () Part time	
JOB TITLE:	LOCATION:	D. O. H.:

Employee Statement: (To be completed by the employee) I, _____ request a leave of absence to begin _____ and to end _____ for the following reason: I have read and fully understand the information contained in our Leave of Absence Policy.

Employee Signature Date
(check one)

<input type="checkbox"/> FMLA	<input type="checkbox"/> Medical	<input type="checkbox"/> Personal	<input type="checkbox"/> Military	Other	
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Explanation:

Extension Request:

I, _____, am currently on a (check one)

<input type="checkbox"/> FMLA	<input type="checkbox"/> Medical	<input type="checkbox"/> Personal	<input type="checkbox"/> Military	<input type="checkbox"/> Other	
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Leave of absence which began on _____. I would like to request an extension to be continued from _____ and to end on _____.

Employee Signature Date

Central Office Use Only

Total Time Requested:	Leave Begins:	Leave Ends:	Return Date:
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Approvals by administration are necessary for **all leave requests**. For **disability leave and FMLA leave** a **physician certificate is required** and date of anticipated return must be attached. **All other leave request requires** a memorandum by the employee and supporting documentation as required by the Human Resources department.

<input type="checkbox"/> DENIED Reason: _____
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APPROVALS:

_____ Immediate Supervisor	_____ Date
_____ Supervisor/ Director	_____ Date
_____ Director of Human Resources	_____ Date
_____ Chief Executive Officer	_____ Date