

CITY OF HICKORY
LEAVE REQUEST FORM
Refer to the City of Hickory Leave Policy

Date: _____

Employee Name: _____

Department: _____

Supervisor: _____

- TYPE OF LEAVE REQUESTED:
- FMLA (COMPLETE FMLA SECTION BELOW)
 - FMLA WORKERS' COMPENSATION (CONCURRENT WITH FMLA)
 - LEAVE WITHOUT PAY
 - SICK LEAVE (NOT FMLA)

DATE WHEN LEAVE WILL START: _____

DATE ANTICIPATED TO RETURN TO WORK: _____

If leave time will be intermittent, list the schedule of time needed off: _____

Note: If leave is for medical reasons, certification from your health care provider may be required.

IF REQUESTING LEAVE WITHOUT PAY, LIST REASON FOR ABSENCE:

IF REQUESTING FMLA:

Does your spouse work for the City of Hickory: YES NO

Reason for taking leave: (check one)

- The birth of my newborn child or placement of a child with me for adoption or foster care.
- To care for my spouse, child, or parent who has a serious health condition.
- My own serious health condition that makes me unable to perform at least one of the essential functions of my job.
- To care for my spouse, son, daughter, parent or next of kin who is a covered service member with a serious injury or illness.

FMLA and WORKERS' COMPENSATION LEAVE: I understand that the City will pay its portion of my medical, dental and life insurance for up to twelve weeks in my consecutive twelve-month period. This twelve-month period is the twelve-month period measured forward from the first time a coworker was approved for FMLA. If my leave exceeds twelve weeks in that period and I have exhausted all accrued leave and compensatory time, I will be on Leave Without Pay and will be responsible for the full cost of the above insurance. I understand that I am obligated to return to work at the end of the leave period. Failure to report shall be considered a resignation, and I may be required to reimburse the City for the cost of my insurance premiums during the 12 week FMLA leave. I understand that I will cease to earn vacation and sick leave on the date that my Leave Without Pay exceeds five working days. Leave Without Pay, including concurrent FMLA, shall not exceed six (6) months.

LEAVE WITHOUT PAY (non-FMLA/Workers' Compensation): I understand that I am responsible for paying all of the cost of my insurance including medical, dental and life once all accrued leave and compensatory time is exhausted. I understand that should my premium payment to the City become 30 days past due, my insurance coverage will lapse at that time. I understand that I will cease to earn vacation and sick leave on the date my Leave Without Pay exceeds five working days. Leave Without Pay shall not exceed six (6) months.

Employee Signature

Date Signed

Supervisor's Signature

Date Signed

Department Head Signature

Date Signed

Human Resources Signature

Date Signed

If request for Leave Without Pay, non-FMLA, exceeds five (5) days, the City Manager's approval is required.

City Manager's Signature

Date Signed