Application for Family or Medical Leave

Name: _____ Dept./Supervisor_____

Current Address: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Reason for Leave:

_____ the birth of a child, or the placement of a child with you for adoption or foster care; or

_____ A serious health condition that makes you unable to perform the essential functions for your job; or

_____ A serious health condition affecting your spouse, child or parent, for which you are needed to provide care.

Name of person: _____ Relationship to me: _____

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 Certification of Health Care Provider (Form WH-380) within 15 days of application for 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 Trinity Rehab, LLC.

Signature: _____ Date: _____

APPROVED BY:

Therapy Program Manager **Date:**

Human Resources Mgr. **Date:**

Director **Date:**