



Education...Empowers...Excellence



Dr. Frank Devono, Superintendent

MEDICAL/FMLA REQUEST FORM

EMPLOYEE INFORMATION

Last Name _____ First Name _____

Employee ID# _____ E-mail Address _____

Home Address _____

City _____ State _____ Zip Code _____

Phone number (____) _____

DEPARTMENT INFORMATION

School Name _____ Position _____

Reason for leave/Procedure date: _____

Approximate Dates of Leave:

Beginning _____ Ending** _____ PAID UNPAID

Applied for Donated Days YES NO

***All requests must be accompanied by FMLA forms, Script or Excuse completed by your Doctor stating the need for and duration of leave.**

****If there is a change in your ending/return date, please contact the Mon.County HR office.
304-291-9210 ext.1501 or 1532**

SIGNATURES

Employee _____ Date _____

Monongalia HR Dept. _____ Date _____

FOR OFFICE USE ONLY

Date received by HR:

Board Approval Date: