Higher Education
Consortium of
Metropolitan St. Louis

MEDICAL LEAVE OF ABSENCE REQUEST FORM

Employee Name: ____ Employee ID: _________ Date: ____________

Address: ____

City State Zip

Home/Cell Phone: _________________Department/Program: _________ Personal E-Mail address: ____________

Employee Statement: *(to be completed by the employee)*

I, ____________________________________, request a medical leave of absence to begin ________________________ and anticipate returning on _________________________________for the following reason: *(check one)*

☐ Birth of a child, or placement of a child for adoption or foster care – Due Date or placement date _____________

☐ Personal medical condition

☐ Family member medical condition for which you are needed to provide care

☐ Other- Please describe: ____

SIGNATURE

I understand that if this request is approved, that:

- failure to return to work at the end of an authorized leave will result in termination of employment unless I have a compelling reason, acceptable to the company, for returning to return to work.
- prior approval in writing is needed for an extension.
- accrued sick and vacation time must be taken as part of the leave.
- the employee may elect to continue certain benefits during the leave for payment of total cost of the premium (employee and employer share).
- prior to returning to work a release report will be required from my doctor.
- further information on leave of absence is in the HEC Employee Handbook.

I have reviewed and understand the conditions and information of my leave of absence request as stated above:

Employee signature: ____ Date: __________________

Approval:

Program Director signature: ____ Date: __________________

Department Director: ____ Date: __________________

HR Administrator: ____ Date Received: ______________________