OHIO HI-POINT Career Center

FAMILY LEAVE REQUEST

(Family Medical Leave Act)

Name	
Date	
Department	
Number of Days Requested	
Beginning Date of Leave	
Final Date of Leave	

Type of Leave

- ◯ Serious personal health condition
- ◯ Serious health condition of family
- ◯ Adoption or foster care of a child
- ◯ Childbirth

By submitting this form, I state that I have read and understand the policy of the Board regarding Family Leave and I agree to abide by its provisions.

Employee