

REQUEST 0 c767 1.056 0.97

Employee name _____ ID number _____

Department _____ Supervisor _____

I understand that a request for an extension of my leave of absence must be received at least one month prior to the expiration of my original leave of absence. Medical certification is necessary for return to work if the leave request is for employee's health condition.

I request permission for an extension of my leave of absence during the period:

From (date) _____ To (date) _____

Reason for extension:

I have exhausted or do not qualify for FMLA.

