VSOLVIT REQUEST FOR TIME OFF

Employee Name		Location	

LENGTH OF TIME REQUEST OFF					
From:		To:		Return To Work On:	
Total Days Requested:		Total Hours Requested:			

TIME OFF REQUEST (Check One)

☐ Vacation ☐ Sick ☐ PTO (if applicable) ☐ Bereavement (if applicable)

OR,

UNPAID LEAVE OF ABSENCE REQUEST (Check One)

☐ Pregnancy ☐ Medical ☐ Family ☐ Personal ☐ Military ☐ Other _____

Utilize Available Vacation During Leave: ☐ Yes ☐ No

Utilize Available Sick During Leave: ☐ Yes ☐ No

If "Personal Leave" or "Other", please provide a brief statement as to the nature of the leave:

I understand that a medical leave is the period of time my physician says I cannot work until the time the physician says I can return to work (not to exceed state and/or federal regulations). All requests for medical and family leave due to the serious illness of a family member must include a physician's statement. For a medical leave based on my own illness, a physician's release showing that I am able to resume my normal job, or any restrictions, must be provided to my supervisor before I may return to work. Failure to provide the physician's statement may lead to the denial of a leave, denial of the continuation of leave, or denial of reinstatement. Please note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I understand that if I accept other employment during the period of this leave, my rights to certain compensation/benefits and position may be reduced or terminated. I acknowledge that it is my responsibility to remain in contact with my supervisor during my leave, and I agree to contact my supervisor at least once a month regarding my status and intent to return to work.

If you fail to return to work on the return date indicated above (unless further approval is obtained or within the time limits described if the return date is left blank), you will be considered as having voluntarily resigned effective on your last day of work.

Employee Signature _____ Date _____

FOR MANAGEMENT USE ONLY

☐ **Approved** ☐ **Denied**

Supervisor/Manager Signature _____ Date _____