CITY OF SCOTTSDALE MEDICAL LEAVE OF ABSENCE NOTIFICATION

Name: _____ Employee #:_____

Address: _____ Home Phone:_____

_____ Department: _____

Supervisor: _____ Supervisor Phone: _____

WORK SCHEDULE – Please indicate the number of hours you are regularly scheduled to work each day:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week 1 # of Hours							
Week 2 # of Hours							

ACTUAL OR ANTICIPATED DATES OF LEAVE:

Leave to Begin:_____ Leave to End:_____

REASON FOR LEAVE: (Please refer to AR #343, Leave Policies to determine eligibility and requirements)

- ☐ Birth of, or to care for, a newborn child
- ☐ Placement of child with you for adoption or foster care
- ☐ To care for: ☐ Your Spouse ☐ Your Child ☐ Your parent with a serious health condition
- ☐ For a serious health condition for yourself

Are you requesting leave for:

- ☐ A continuous absence
- ☐ Irregular intermittent absence
- ☐ Scheduled intermittent leave/reduced work schedule

Are you enrolled in the City's Short Term Disability Plan? **Yes** _____ **No** _____

If yes, all accrued medical leave must be exhausted and a complete Short Term Disability Claim Form must be submitted before any benefits can begin. Please contact Human Resources – Benefits at 480-312-7600 to file a claim.

Is your leave of absence Worker Comp-related? **Yes** _____ **No** _____

If yes, please contact Risk Management to file a Worker's Comp claim.

Please Note: You are responsible for notifying your supervisor and/or timekeeper of how your timesheet should be completed in your absence. You may be required to use all accrued leave, as applicable, during your leave of absence. Please refer to AR 343, Leave Policies.

Signatures below acknowledge the department is aware of the employee's request for a leave of absence.

Employee: _____ Date: _____

Human Resources: _____ Date: _____

Supervisor: _____ Date _____

Department Director (or above): _____ Date: _____

FOR HR USE ONLY:

Date of Hire: Hours Worked: FMLA Eligible? Yes No