<u>Family or Medical Leave Form</u>

(Certification of Health Care Provider **must be** submitted to the Personnel Office within fifteen days of filing this form)

Name: ____

Department: ____

Current Address: ____

State Date of Anticipated Leave: ____

Expected Date of Return to Work: ____

Reason(s) for Leave (Explain): ____

____

____

NOTE: A family or Medical Leave is based on an employee's serious health condition or the serious health condition of an employee's spouse, child, or parent AND must be accompanied by a verifying medical certification from a physician.

I further understand that by signing below, I am acknowledging that: (check one)

☐ the condition is not a work related illness/injury.

☐ the condition is a work related illness/injury.

☐ the condition may be a work related illness/injury

I hereby authorize Cortland County to contact my physician for the release of any medical information necessary to verify the reason for the leave under the FMLA.

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by the County.

Signature: ______________________________ Date: ______________________

APPROVED BY: ____

Administrative Use Only:

☐ Work related ☐ Undetermined

☐ Non-work related