

Please print legibly. Do not complete this form for personal/vacation requests, or other leave not exceeding more than 3 days. For those requests please complete the PTO Authorization Form.

GENERAL

Division/Location: Dept: Employee ID#: Date:
Employee Name: Last First MI
Email Address: Phone Number:
Current Address: Street City State Zip

TYPE OF LEAVE

Date Leave Begins: Date Leave Ends:
Is this a work related injury? Yes No
Will this leave be: Continual Intermittent Unknown at this time
Medical Leave - Personal Illness or Injury
Personal - Medical needs of: Child Spouse Parent
Personal - Birth, adoption or foster placement of child
Military
Comments:
(You may attach supporting documents)
I am requesting approval for a leave of absence from work for the reason(s) and period stated above.
Employee Signature: Date:

FACILITY ADMINISTRATION

Facility Administrator: Facility Human Resources Contact/BOM:
Print Name Print Name
Employee Supervisor:
Print Name
Please submit this form with a copy of the employee's signed job description to Corporate Human Resources at LOA@libertyhcare.com or via fax to 910-815-4356

Form Received by:
Position Title: Name: Signature: Date: / /