Liberty Healthcare **REQUEST FOR LEAVE OF ABSENCE**

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: _____ Employee ID#:_____ Date: _____

Position: _____

Employee Name: _____
Last First MI

Email Address: _____ Phone Number: _____

Current Address: _____
Street City State Zip

Emergency Contact: _____ Emergency Contact Phone Number: _____

TYPE OF LEAVE

Date Leave Starts: _____ Date Leave Ends: _____

Is this a work related injury? Yes ☐ No ☐

Will this leave be: ☐ Continuous (block of time) ☐ Intermittent ☐ Reduced Schedule ☐ Unknown

☐ 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: _____

EMPLOYEE MANAGEMENT

Facility Administrator: _____ Facility Human Resources/BOM Contact: _____
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 910-765-9204

Revised 10.2023