State of Colorado
LEAVE/ABSENCE REQUEST AND AUTHORIZATION

Name:

Department and Division:	**Work Phone:**

I understand that leave must be requested and approved in advance, where foreseeable. I understand that I must provide sufficient information so the proper type of leave can be determined. I understand that I am responsible for keeping my supervisor informed of any change in this request. If a medical condition is highly sensitive, immediately contact the Department's Family/Medical Leave coordinator *(Tamy Calahan)* directly.

I request approval for _____ - _____ total hours as listed below.   Is the absence due to a work-related illness or injury?   No _____   Yes _____

Annual (not related to care/treatment of a medical condition or bonding with a new child)

From (Date, Time)	To (Date, Time)	# of Hrs.	

Medical (Routine Eye, medical, dental exam, common illness, injury, other medical, etc.)
If not self, relationship (parent (biological or in loco parentis), child under 18 years, adult child incapable of self-care, spouse, legal dependent, or person in the household for whom the employee is the primary caregiver)

Other (give reason/details, e.g., alternate holiday, comp time used, administrative, funeral, jury duty, military, injury on duty, education, leave of absence)

Attach additional information for funeral, jury duty, military, volunteer/community service.

Employee Signature: _____   Date: _____   Mark here if this is an amended form (X): _____

To Be Completed By Appointing Authority (or Designee)

___ Annual	___ FML - Sick (Family)	___ Administrative including Volunteer/Community Service	___ Leave of Absence
___ Sick	___ FML - LWOP	___ Funeral	___ Injury on Duty
___ Sick (Family)	___ FML - STD	___ Jury Duty	___ Voluntary Furlough
___ STD	___ FML - Holiday	___ Military	___ Other (give reason/details):
___ FML - Annual	___ Alternate Holiday	___ Education	
___ FML - Sick	___ Comp Time Used	___ LWOP	_____

A medical certification _____ is required _____ is not required (X) before returning to work on a regular basis.
(definitely required for an absence of more than three full consecutive working days)

A fitness-to-return certification _____ will be required _____ will not required (X) before returning to work on a regular basis.
(definitely required for an absence over 30 calendar days due to an employee's health condition)

MANDATORY - For purposes of family/medical leave (FML) designation, I have determined, as the appointing authority or designee, the following:

___ The employee is not eligible for FML until _____ (date).

___ The employee is eligible for FML but has already used the hours allowed in this fiscal year.

___ The event does not qualify for FML.

___ The employee is eligible for FML, and the event does, or could, qualify for FML.
(The State of Colorado Employer Individual Notice for FML form must be completed and given to the employee within two business days of this request, absent extenuating circumstances.)

___ This is a continuation of a previously designated event (continuing treatment or recovery).

Approved by: _____   Date: _____
Immediate Supervisor or Designee Signature

Approved by: _____   Date: _____
Appointing Authority, Designee, or FML Coordinator Signature

Posted by: _____	Date: _____

Any medical information is confidential and must be kept in separate files with limited access.