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 (Tommy 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)

Employee Signature: ___________ Date: ___________

Mark here if this is an amended form (X):

To Be Completed By Appointing Authority (or Designee)

<table>
<thead>
<tr>
<th>Annual</th>
<th>FML - Sick (Family)</th>
<th>FML - LWOP</th>
<th>Administrative including Volunteer/Community Service</th>
<th>Leave of Absence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick</td>
<td>FML - STD</td>
<td>FML - Holiday</td>
<td>Jury Duty</td>
<td>Military</td>
</tr>
<tr>
<td>Sick (Family)</td>
<td>FML - LWOP</td>
<td>FML - Annual</td>
<td>Alternate Holiday</td>
<td>Education</td>
</tr>
<tr>
<td>STD</td>
<td>FML - Sick</td>
<td>Comp Time Used</td>
<td>LWOP</td>
<td>Leave of Absence</td>
</tr>
</tbody>
</table>

A medical certification is required (X) before returning to work on a regular basis.

A fitness-to-return certification is required (X) before returning to work on a regular basis.

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 _____________.

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 Employee 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: ___________ Immediate Supervisor or Designee Signature: ___________ Date: ___________

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

Posted by: ___________ Date: ___________

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