EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

I, _____, an employee with Sampson County_____ Department would like to request leave from _____to _____ for the following reason(s):

Medical Leave (family or self) _____
(Length of Leave Requested)

Family Maternity/Child Placement _____
(Length of Leave Requested)

I understand that I must meet the guidelines for this leave and attach a physician's certification or justification of the medical leave (whether on myself or a family member). I further acknowledge that I will be responsible for any co-payment in regard to any insurance deduction. In the event of my failure to return to work, I understand that I may have to reimburse the County for any premiums paid for Blue Cross health insurance and to Prudential for dental insurance for any premiums paid for insurance during my absence.

Pay-back will be determined by the current cost of the premium multiplied by the number of months, or partial months (based on our personnel resolution, an employee's insurance will be paid if he/she is in a leave earning capacity for at least one-half (1/2) of the month) of leave-without-pay.

I am aware that any paid leave (sick or vacation), which I have earned or will earn while on paid leave, will be exhausted before leave-without-pay will be considered.

_____ _____
Employee's Signature Date

Recommending approval/disapproval

_____ _____
Department Head's Signature Date

Recommending approval/disapproval

_____ _____
County Manager's Signature Date

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Leave Balances for Finance Office Use Only

Vacation Leave _____ Sick Leave _____ FMLA _____

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A copy of this form was returned to the employee on _____ by mail (_____) or interoffice correspondence (_____).