

MOUNT SINAI SCHOOL OF MEDICINE
REQUEST FOR LEAVE OF ABSENCE

EMPLOYEE NAME _____ DEPARTMENT _____

PERIOD FOR WHICH LEAVE IS REQUESTED:

From: _____ To _____

Last Day Worked: _____ Date of Return: _____

Purpose of Leave (Explain fully):

I understand that the above requested leave of absence, if approved, has been granted on the following conditions:

1. I must report to work on the "date of return" indicated above;
2. If I am unable to return on the date noted above, I will submit a written request for an extension to my Chairman/Director. The extension request must be submitted at least two weeks prior to the scheduled date of my return;
3. I must confirm my return to work date with my Chairman/Director at least two weeks in advance of the date specified;
4. I understand that prior to return from a medical/maternity leave of absence, I must submit a physician's note to the hospital's Employee Health Service and obtain clearance;
5. I understand that failure to comply with the conditions as stated may result in my termination from employment.
6. This leave will be counted towards my Family and Medical Leave Act entitlement (to a maximum of twelve (12) weeks per year) with continuation of medical coverage, if applicable.

Date

Employee Signature

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ABOVE REQUESTED LEAVE OF ABSENCE HAS BEEN:

- Rejected _____
Signed
- Approved _____
Signed

