Application for Extension of Family or Medical Leave

Company Name (refer to as *The Company*): _____

Name: _____ Badge number: _____

Current Address: _____ Department: _____

_____

_____

_____

Reason for Leave (please be as detailed as possible) : _____

_____

_____

_____

_____

_____

Date(s) of leave	Hours Off	Date(s) of leave	Hours Off

(Leave Hours Off blank if full day will be taken)

A leave request based on an employee's serious health condition or the serious health condition of an employee's spouse, child or parent must be accompanied by a medical certification of need from an applicable health care service provider.

I hereby authorize *The Company* or it's agents (HRS/TND Associates, Inc.) to contact my health care service provider for purposes of clarification regarding my requested leave.

(initials) _____

I understand that a failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by *The Company*.

(initials) _____

Signature: _____ Date: _____

(Attach additional forms if necessary)

HRS/TND Associates, Inc. FMLA Services
4 Park Plaza, Reading, PA 19610
Phone 610-371-9505 Fax 610-373-8618