LEAVE NOTIFICATION

Department use only

Employee Name _____ **Employee #** _____ **Date of Hire** _____

Employee Address _____ **Telephone #** _____

Department _____ **Position** _____ **Status: FT** ☐ **PT** ☐ **Temporary** ☐

Available PTO Hours _____ **Available EIB Hours** _____ **FMLA used in the last 12 months** _____

☐ **FMLA**

☐ **FMLA Intermittent**

☐ **Leave of Absence (LOA)**

☐ **Leave of Absence Without Pay**

☐ **Military Leave**

☐ **Return from Leave**

_____ _____

Court HR Signature **Date**

Benefits Use Only

FMLA Letter Sent ☐ **Yes** ☐ **No** **Date Letter Sent** _____

Effective Date _____ **End Date** _____

FMLA Application/Medical ☐ **Yes** ☐ **No** **Date Received** _____

Worker's Comp or STD ☐ **Yes** ☐ **No** **Start Date** _____ **Return Date** _____

Long Term Disability ☐ **Yes** ☐ **No** **Start Date** _____ **Return Date** _____

Benefits:

Medical	**$**_____**Biweekly**	**$**_____**Monthly**	**COBRA:**
Dental	**$**_____**Biweekly**	**$**_____**Monthly**	**$**_____**Monthly**
Vision	**$**_____**Biweekly**	**$**_____**Monthly**	**$**_____**Monthly**
FSA	**$**_____**Biweekly**	**$**_____**Monthly**	**$**_____**Monthly**
Lincoln	**$**_____**Biweekly**	**$**_____**Monthly**	
AFLAC	**$**_____**Biweekly**	**$**_____**Monthly**	
Nationwide	**$**_____**Biweekly**	**$**_____**Monthly**	
ICMA	**$**_____**Biweekly**	**$**_____**Monthly**	
Total	**$**_____**Biweekly**	**$**_____**Monthly**	

_____ _____

Benefits Administrator Signature **Date**

Original –Benefits

Copy – Payroll