



State of Colorado LEAVE/ABSENCE REQUEST AND AUTHORIZATION

Name: _____

Department and Division: **DMVA** _____ 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 (*Tamy Calahan*) directly.

I request approval for _____ - _____ total hours as listed below. Is the absence due to a work-related illness or injury? No Yes (X)

Record dates, times, and number of hours in the blanks before each applicable reason. (More information may be required.)

From (Date, Time)	To (Date, Time)	# of Hrs.	
_____	_____	_____	Annual (not related to care/treatment of a medical condition or bonding with a new child)
_____	_____	_____	Medical If not self, relationship (see below): _____ parent (biological or <i>in loco parentis</i>), 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
_____	_____	_____	
_____	_____	_____	-Routine eye, medical, dental exam
_____	_____	_____	-Common illness/injury (no prescribed treatment, e.g., cold, flu)
_____	_____	_____	-Other Medical (inpatient or continuing treatment, e.g., surgery, childbirth). Reason: _____
_____	_____	_____	Other (give reason/details, e.g., alternate holiday, comp time used, administrative, funeral, jury duty, military, injury on duty, education, leave of absence): _____
_____	_____	_____	

Attach additional information for funeral, jury duty, military, volunteer/community service.

Employee Signature: _____ Date: _____ Mark here if this is an amended form (X): _____

Approved by: _____ Date: _____
Immediate Supervisor or Designee Signature

To Be Completed By Appointing Authority (or Designee)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Annual | <input type="checkbox"/> FML - Sick (Family) | <input type="checkbox"/> Administrative including Volunteer/Community Service | <input type="checkbox"/> Leave of Absence |
| <input type="checkbox"/> Sick | <input type="checkbox"/> FML - LWOP | <input type="checkbox"/> Funeral | <input type="checkbox"/> Injury on Duty |
| <input type="checkbox"/> Sick (Family) | <input type="checkbox"/> FML - STD | <input type="checkbox"/> Jury Duty | <input type="checkbox"/> Voluntary Furlough |
| <input type="checkbox"/> STD | <input type="checkbox"/> FML - Holiday | <input type="checkbox"/> Military | <input type="checkbox"/> Other (give reason/details): _____ |
| <input type="checkbox"/> FML - Annual | <input type="checkbox"/> Alternate Holiday | <input type="checkbox"/> Education | _____ |
| <input type="checkbox"/> FML - Sick | <input type="checkbox"/> Comp Time Used | <input type="checkbox"/> LWOP | _____ |

A medical certification is required is not required (X) before returning to work on a regular basis.
(definitely required for an absence of more than three full consecutive working days)

A fitness-to-return certification will be required will not required (X) before returning to work on a regular basis.
(definitely required for an absence over 30 calendar days due to an employee's health condition)

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 _____ (date).

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 Employer 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: _____ Date: _____
Immediate Supervisor or Designee Signature

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

Posted by: _____ Date: _____