SMITH COLLEGE

Office of Human Resources
Garrison Hall
42 West Street
Northampton Mass. 01063

Employee Medical or Family Leave of Absence Request Form

Name: _____ Smith ID#: _____

Position: _____ Department: _____

Date of Hire: _____

Type of leave requested (check one):

☐ Intermittent/Reduced Schedule ☐ Continuous

Reason for leave (check one):

☐ Own Serious Health Condition

☐ Care of family member (please list relationship) _____

☐ Qualifying Exigency

Start date of Leave of Absence: _____ **Expected return to work date:** _____

I understand that by requesting this leave of absence, I am committed to returning to work on the date specified.

Employee Signature: _____ **Date:** _____

Use by Benefits Department Only:

Eligible Leave Type: ☐ FMLA ☐ PFML

Pay for leave: ☐ Accrued Time ☐ Accrued Time/SLB ☐ PFML Benefits Only ☐ PFML & Accrued Time ☐ WC

☐ Emailed copy to Manager/Supervisor