



Leave of Absence Request

This form must be submitted to your supervisor 30 days in advance, or as early as the need for time off is known, with any appropriate documentation

Employee Name: _____

AEG Entity: _____

Position: _____

Full Time Part Time Cast and Crew/CAPS

Type of Leave: Bereavement Military
 Employee Medical Leave* Occupational Injury/Illness
 Family Medical Leave* New Child Leave*
 Jury Duty Pregnancy*
 Medical Disability* Other (explain)

If Leave is for "Other" Reasons, Please Explain: _____

** If request is for Employee Medical Leave, Family Medical Leave, Medical Disability Leave, New Child Leave or Pregnancy Leave, a medical certification form should be submitted with this request or must be submitted no later than 15 days after the date of this request. If additional time is needed, a medical certification form explaining the additional time is required.*

First Day Off: Day of the Week: _____ Date: _____

Last Day Off: Day of the Week: _____ Date: _____

I Will Return to Work On: Day of the Week: _____ Date: _____

I do _____ I do not _____ wish to continue my health insurance during my absence. (NOTE: This will not affect workers' compensation benefits)

Contact Phone Number During My Leave: _____

By signing below, I understand that if I am unable to return to work by the scheduled return date, my Human Resources Representative must be notified in writing at least 5 days prior to the expiration of the original leave explaining the reason for the extension and the length of time required. I further understand that if I do not return to work on the date listed above, or if I have not requested and received a written extension of my original leave, I will have voluntarily resigned.

Employee Signature Date

EMPLOYER SECTION: Request for Leave of Absence is: Approved Not Approved

If Rejected, State Reason: _____

Supervisor Signature Date

AEG Human Resources Manager Signature Date