

Leave Request Form

Employee Name: _____	Employee No.: _____	
Date Requested: _____		
Type of Leave Requesting:		
<input type="checkbox"/> PTO	<input type="checkbox"/> Jury Duty **	<input type="checkbox"/> Short Term Disability (STD) **
<input type="checkbox"/> Bereavement Leave ** 3 Consecutive Days	<input type="checkbox"/> Military Activation Leave **	<input type="checkbox"/> Long Term Disability (LTD) **
	<input type="checkbox"/> Family and Medical Leave (FMLA) **	<input type="checkbox"/> Leave Without Pay (LWOP) **
I hereby request leave for the following day(s):		
First Day Off _____	to	_____ Last Day Off
I will return to work on: _____		
Employee Signature: _____		
Supervisor Signature: _____		

NOT APPROVED: _____		
Remarks: _____		

<u>Notes:</u>		
1. Please read program specific information for terms and conditions.		
2. Attach supporting documentation where applicable. Incomplete requests will be returned.		
3. If an employee fails to return to work after the expiration of approved leave, BCF will assume the employee has resigned. All Company-paid health insurance premiums may be recovered from the employee.		
** Signed form required to be forwarded to Human Resources		