



CITY OF CAMDEN MEDICAL LEAVE REQUEST FORM

TO: Christine T.J. Tucker, Business Administrator

FROM:

Employee Name

Address

City, State, Zip

Home Phone:

Cell Phone:

E-Mail Address:

(Failure to prove above information shall result in the delay/denial of your leave of absence)

I respectfully request a medical leave of absence for _____ days, months, beginning _____ and ending _____. The leave is to be with without pay. Supporting documentation is attached.

I understand that failure to return to work within five (5) working days of the above ending date will result in provisions of NJAC 4A:2-6.2 (c) being applied. In the event that I require an extension of this leave, a written request will be submitted at least three (3) days prior to the end of this leave.

Signature

Date

Approved

Disapproved

Business Administrator

Date

C: Department Director
Payroll
Health Benefits
Personnel File