WICHITA CENTER FOR GRADUATE MEDICAL EDUCATION, INC.
REQUEST FOR FAMILY OR MEDICAL OR SERVICE MEMBER'S LEAVE OF ABSENCE

Employee's Name: ______________________________ Today's Date: _________________

Address: ____

City: _______________________________ State: ________ ZIP: __________

Does your spouse work for this company?

☐ Yes ☐ No

Reason for taking leave: (check one)

☐ to care for my child after birth or placement in adoption or foster care;
☐ to care for my spouse, child, or parent who has a serious health condition;*
☐ my own serious health condition makes me unable to perform at least one of the essential functions of my job;
☐ Military caregiver leave; * or
☐ Qualifying military exigency leave.*

For leave to be taken all at once, rather than intermittently or on a reduced workweek:
Date leave is to start: _________________________
Date I expect to return to work: _________________

For leave to be taken intermittently or on a reduced workweek:
Schedule of time needed off: ____
____
____
____

* Please attach reasonable documentary proof of familial relationship if requesting leave to care for a family member. These documents will be returned to you following examination by the Chief Operating Officer.

NOTE: Intermittent or reduced-schedule leave for the birth or placement of a child is subject to WCGME's approval.

_________________________________ _________________________
(Employee's Signature) (Date)

_________________________________ _________________________
(Program Director's Signature) (Date)