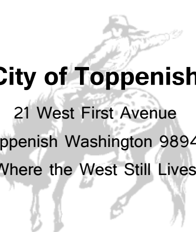

City of Toppenish
21 West First Avenue
Toppenish Washington 98948
"Where the West Still Lives"

REQUEST FOR FAMILY MEDICAL LEAVE

Date of request: ______________________________

Employee name: ______________________________

Department: ______________________________

Social Security Number: ______________________________

Leave Category Requested:

☐ Paid Leave

☐ Unpaid Leave

☐ Other: (explain) ______________________________

____

____

Reason for Leave:

☐ Employee's own illness

☐ Care for new child

☐ Ill family member - Relationship ______________________________

☐ Other: (explain) ______________________________

____

____

Beginning date of leave: ______________________________

Ending date of leave: ______________________________

Address during leave: ______________________________

Phone # during leave: ______________________________

______________________________ ______________
Employee Signature Date