Leave Request Form

(to request leave or other absences)

Cobb County...Expect the Best!

Legal Name: _____ Employee I.D. #: _____
Please Print

Department: _____ Division: _____ Date of Hire: _____

Beginning Date: _____ Time: _____ End Date: _____ Time: _____

FOR LEAVE OF ABSENCE REQUEST ONLY

Last Day Worked: _____ Actual Date Returned to Work: _____

Is this an extension of the original leave request? ❑ Yes ❑ No

Family Medical Leave*: Is this leave request for a serious health condition, either for you or for a qualified family member, or for the birth/adoption of a child? ❑ Yes ❑ No

Type of Leave Requested (leave usage is limited to 15-minute increments.) ❑ **Paid** ❑ **Unpaid**
(Note: Leave cannot be taken until the hours are reflected on your paycheck stub.)

Annual Leave: _____ Hours Available Hours: _____

Compensatory Leave: _____ Hours Available Hours: _____

Sick Leave: _____ Hours Available Hours: _____

Other Leave: (attach appropriate documents) ❑ Military Leave ❑ Jury Duty ❑ Bereavement

Number of Actual Work Days for Request: _____

Comments: _____

(Please check if applicable)

❑ In accordance with the Workers' Compensation Policy, I elect to utilize my available leave balance during the period of disability as a result of a work-related injury to the extent of the difference between Workers' Compensation pay and my regular salary. I further understand that my leave hours will be decreased by the hours used to supplement my salary.

Purpose of Request: _____

Projects or activities to be covered during absence: _____

Person responsible for activities during absence: _____

*An employee who has been on a leave of absence for a period of 30 calendar days or longer shall notify the Department Head/Agency Head/Elected Official of his/her intention of returning at least **10 calendar days prior to returning from leave.** Employees taking an unpaid leave of absence must contact Human Resources to arrange for the payment of benefit plans during their leave. **Failure to make the required payments will result in the termination of plan coverage.***

Employee's Signature: _____ Date: _____

❑ Approved ❑ Disapproved _____ Date: _____
Supervisor or Division Manager

❑ Approved ❑ Disapproved _____ Date: _____
Department Head or Elected Official

❑ Approved ❑ Disapproved _____ Date: _____
County Manager (for Leave of Absence approval over 2 wks)

* Family Medical Leave may be paid (i.e. charged to the employee's existing sick, annual or compensatory leave) or unpaid in the absence of such leave.

EMPLOYEE MUST BE PROVIDED WITH A COMPLETED, SIGNED COPY OF THIS FORM.

Revised: 3/22/19