Florida Institute of Technology

LEAVE OF ABSENCE REQUEST FOR EXTENSION

EMPLOYEE NAME _____ ID # _____

DEPARTMENT _____ SUPERVISOR _____

I understand that a request for an extension of my Leave of Absence must be received at least one month prior to the expiration of the original Leave of Absence. Medical certification is necessary for return to work if the leave request is for employee's health condition.

I REQUEST PERMISSION FOR AN EXTENSION OF MY LEAVE OF ABSENCE:

FROM *(date)* _____ TO *(date)* _____

REASON FOR EXTENSION _____

_____

_____

_____ _____

Employee's Signature Date Supervisor's Signature Date

☐ Approved: Normal work load of this employee will be covered as follows _____

_____

_____

☐ Not Approved: Reason _____

_____

_____ _____

Dean, Director, Head or Chair's Signature Date Vice President's Signature Date

APPROVED _____

Associate Vice President of Human Resources' Signature Date