



## CITY OF CAMDEN MEDICAL LEAVE REQUEST FORM

**TO:** Robert Corrales, 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