

**JOHNSTOWN MILLIKEN EDUCATION ASSOCIATION
FAMILY LEAVE ASSISTANCE PROGRAM**

Date _____

Employee Name _____

Home Address _____

School _____

A Physician's Statement on this form specifying the nature of illness or injury, dates of medical service, and a statement of medical necessity for the employee to be in attendance is required.

PHYSICIAN'S STATEMENT _____

Name of Physician (Please Print) _____

Physician's signature _____ Date _____

(Below this line for office use only)

First Day Missed _____ Total Days Absent from Work _____

Date Returned to Work _____ Total Days Requested _____

NOTE: REQUEST FOR FAMILY LEAVE ASSISTANCE DOES NOT INSURE DONATION OF DAYS. DAYS UTILIZED BUT NOT DONATED WILL BE DOCKED.