**Medical Leave Request Form**

*Formal request for short-term medical leave supported by a doctor’s note*

**Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | **Employee ID:** |  |
| **Department:** |  | **Position/Title:** |  |
| **Contact Number:** |  | **Email Address:** |  |

**Leave Details**

|  |  |
| --- | --- |
| **Type of Leave Requested:** | □ Medical Leave (Short-Term) |

**Reason for Leave (brief description):**

|  |
| --- |
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|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date:** | \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ | **End Date:** | \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ |
| **Total Days Requested:** |  | | |

**Doctor’s Note / Medical Certificate**

*(Attach supporting document)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Healthcare Provider:** |  | **Clinic/Hospital Name:** |  |
| **Date Issued:** |  | **Verified Condition (optional if allowed):** |  |
| **Medical Restrictions / Special Instructions (if any):** |  | | |

**Employee Declaration**

I hereby request short-term medical leave for the dates stated above. I confirm that the information provided is accurate and that the attached doctor’s note supports my need for leave.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

**Supervisor/Manager Review**

* **Approved:** □ Yes □ No
* **Comments:**

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| --- |
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|  |  |  |  |
| --- | --- | --- | --- |
| **Manager Name:** |  | | |
| **Signature:** |  | **Date:** | \_\_\_\_ / \_\_\_\_ / \_\_\_ |

**HR Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Leave Recorded in System:** | □ Yes □ No | **Supporting Documents Verified:** | □ Yes □ No |
| **HR Comments:** |  | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Processed By (HR):** |  | **Date:** |  |