REQUEST FOR EXTENSION FORM

Please return completed form to Absence Management
14201 School Lane, Room 132. Upper Marlboro, MD 20772
Phone: 301-952-6200. Fax: 301-760-3593. Email: absence.mgmt@pgcps.org

Employees should submit the request for extended leave form at least **10 days** before the end date of current approved leave. An employee may be placed on unapproved/unpaid leave if the completed documents are not received within the allotted time. Please contact Absence Management at (301) 952-6200 if you have any question about the extended leave process.

Employee's Full Name		**EIN**
Home/Cell Number	**Email address**	
Job Organization	**Location**	**Job Title**

Requested Time of Extension -- Beginning date: _____/_____/_____ **Ending date:** _____/_____/_____ **(Non-Medical Request Only).** **Month Day Year** **Month Day Year**

Employee Signature: _____ **Date:** _____

*****MUST PROVIDE SUPPORTING DOCUMENTATION EXPLAINING REASON FOR EXTENDING YOUR LEAVE*****

Type of Extension Requested (Select One):

◯ Employee Medical Leave	◯ Military Leave – Submit Military Orders	◯ Personal Leave – Bonding with baby
◯ Employee Family Medical Leave	◯ Military Family Leave – Submit Military Orders	◯ Other Personal Leave - Submit Supporting Documentation

THIS SECTION TO BE COMPLETED BY A MEDICAL PHYSICIAN ONLY

Diagnosis & ICD-9- Code(s)	Prognosis	Severity of Condition	Impact on Essential Job Function

CHOOSE ONLY ONE OPTION BELOW:

◯ Will the employee's absence be for a continuous period, including any time for treatment and recovery?

Beginning date: _____/_____/_____ **Ending date**: _____/_____/_____ (**estimated ending date**)
Month Day Year Month Day Year

OR

◯ Will the employee still continue to work will receiving treatment /recovery (**intermittent leave**)?

Beginning date: _____/_____/_____ **Ending date**: _____/_____/_____
Month Day Year Month Day Year

Frequency of treatment/recovery: # of days per month _____ (**8 days max**)

Surgery/Procedure:_____ Actual/Anticipated Date of Surgery:_____

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Health Care Provider's Name: _____ **Provider's ID #** _____ **(Required)**

Type of Specialty: _____

Business Address: _____

Signature of Health Care Provider: _____ **Date:** _____ **Telephone: (_)** _____