

ODNR Employee Call IN/OFF Form

Employee Name: _____ Div./Office - Work Area: _____

Time of Call: _____ Work Schedule: _____ Date of Absence: _____

Reason:

____ Illness
____ Bereavement
____ Accident
____ Other

Family Illness

____ Spouse
____ Son/Daughter
____ Parent
____ Other _____
(specify)

Type of Leave:

____ Sick Leave
____ Vacation (emergency)
____ Vacation (in lieu of sick leave)
____ Personal (emergency)
____ Personal (in lieu of sick leave)
____ Other _____

Comments: _____

1. How long are you going to be absent? _____
 2. Will you be hospitalized? _____ In-Patient _____ Out-Patient _____
 3. Have you seen a doctor? Yes No Are you going to see a doctor? Yes No
 4. Are you under continuing care or treatment? Yes No If **yes**, for how long? _____
 5. If **your** absence is due to the illness of a family member, what care are you providing? _____
 6. Have you requested or been informed this illness/condition qualifies for either:
 FMLA ADA
Family Medical Leave American Disabilities Act
Act
 7. Phone number where you can be contacted: _____
- Call taken by: _____

Supervisor Section:

Did you notify the employee that this leave qualifies as FMLA and will be credited toward his or her 12 week yearly entitlement?
Yes - Date of Notification _____ No

Supervisor Acknowledgment _____ Date _____ Follow-up Contact Date (if necessary) _____

Note: The employee should not be asked to disclose confidential medical information (i.e., diagnosis or prognosis). He/she need only indicate an excusable medical condition. Human Resources may follow-up to determine whether that condition would constitute FMLA eligibility.

*This form should be attached to the employee's Request for Leave Form.