Texarkana
Independent School District

EMPLOYEE REQUEST FOR MEDICAL LEAVE

Employee Name:_____ Campus/Position: _____

First Day Out_____ Approximate Time Out _____

Reason for Absence _____

_____

_____

This form must be completed for any employee out on leave *(medical, worker's compensation, personal, etc.)* who has been out for more than five days or you anticipate will be out for more than five days.