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Rev:	**C**
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Request of Leave of Absence

(must be provided 30 days prior to actual leave, if foreseeable)

Name: _____
Supervisor/Manager: _____
Date of Hire: _____

- For leaves due to your own or a family member's serious health condition, a medical certification for is required.
- You may use Paid leave (PTO) to cover any waiting period for your leave of absence.
- During leave of absence employees will not accrue PTO nor receive bereavement or holiday pay.
- Failure to return from a Leave of Absence on the agreed upon date without an approved extension will result in termination for job abandonment.
- See HR for additional information

Type of Leave Request:

_____ **Parental:**

_____ Birth — Expected birth date:_____
_____ Adoption — Expected placement date:_____
_____ Foster Care Placement — Expected placement date:_____
_____ Child Court Order — Expected placement date:_____

_____ **Illness in immediate Family. Serious health condition of:**

_____ Employee
_____ Family Member Name:_____
Relationship:_____

_____ **Personal**

_____ Personal Business
_____ Personal Tragedy
_____ Military
_____ Other

_____ **Medical** (see Human Resources for additional request and certification forms)

Desired start date of leave:_____

Expected end date of leave:_____

Intermittent or reduced schedule leave (explain desired time off):_____

_____

Employee Member Signature:_____ Date:_____

FOR HR ONLY

Leave of Absence Condition:

Last day worked _____ Return to work date _____

Pay: STD (elimination period) _____ days

PTO (non STD) _____days

No Pay _____ days

Check insurance to be continued and the weekly cost to employee:

Medical	() Yes	() No	() N/A	$_____
Dental	() Yes	() No	() N/A	$_____
Vision	() Yes	() No	() N/A	$_____
Other	() Yes	() No	() N/A	$_____
Total insurance premium due per week:				$_____

Payment of insurance premiums by Employee:

☐ Pay weekly in advance through payroll deduction

☐ Employee to submit a check

☐ Premiums to be taken upon return from leave

Employee:

☐ Resumed work part-time

☐ Resumed work full-time

☐ Resumed modified duty (explain) _____

☐ Other (explain)_____

Completed by _____ Date _____

I recommend that this leave be approved:

☐ With Pay

☐ Without Pay

I recommend that this FMLA/PFML leave be approved:

☐ With Pay

☐ Without Pay

Number of FMLA/PFML weeks available: _____

Job will be held (LOA not FMLA eligible)

☐ Not Eligible for FMLA

Authorized Signature _____ Date _____

REVISION HISTORY

Rev.	ECO No.	Revision date	Revised by:	Description of Change
Rev.A	None	5/2018	AF	First document
Rev.B	3027	7/17/2019	AF	Combined LoA and FMLA
Rev.C	3145	10/8/2019	SP	Added vision and premium payment method
Rev.D				
Rev.E				