Leave of Absence Form

Employee Name: _____ Date: _____

Location/Department: _____

I. LENGTH OF LEAVE

I request time off from work from _____ to _____
Total number of days off (if known): _____
Is this leave intermittent leave? ☒ Yes ☐ No
Total number of sick days available: _____
Verified by: _____ Date: _____

II. TYPE OF LEAVE (Check all that apply)

- ☐ Family or Medical Leave Act [FMLA Leave]
- ☐ Long Term Disability Leave [LTD Leave]
- ☐ Medical Leave [MLA Leave]
- ☐ Other: Please Specify:
- ☐ Military Leave
- ☐ Workers' Compensation Leave [WCLA Leave]

III. REASON FOR FMLA LEAVE (Only complete if you selected FMLA Leave in Section II)

My request for time off from work is related to the following:

- ☐ The birth of a son or daughter, or to care for a newborn child
- ☐ Placement of a child for adoption or foster care with me
- ☐ Care of my spouse, child, or parents with a Serious Health Condition*
- ☐ A serious Health Condition that makes me unable to work at all or unable to perform any one of the essential functions of my job
- ☐ Military Caregiver [up to 26 weeks]
- ☐ Qualified Exigency Leave

NOTE: Please consult the FMLA Policy or the Director of Human Resources or appropriate Administrator for eligibility requirements for an FMLA leave and a definition of the FMLA term "Serious Health Condition." Human Resources will provide the employee with the appropriate certification to be completed prior to the employee's leave.

IV. MEDICAL PLAN COVERAGE

EMPLOYEES WHO PARTICIPATE IN THE MEDICAL INSURANCE PLAN MUST INITIAL BELOW.

If I am on a **paid** FMLA or MLA leave, I understand that my portion of any applicable medical insurance premium will be paid through payroll deduction during that portion of the paid FMLA or MLA leave. If the FMLA or MLA leave is **unpaid**, I agree to pay my portion of that premium on or before the first day of each month while I am on leave. During the time I am on FMLA leave, my portion continues to be the amount I paid for coverage as an active employee. I understand that if I am on unpaid MLA leave I am responsible for the **full cost** of the medical insurance plan, including the portion my employer paid before my leave. I understand that if payment is not made timely, my medical coverage will be canceled. In order to continue any applicable group health insurance after the expiration of any applicable MLA leave, I understand I must make a Continuation of Coverage Election.

Employee's Initials: _____ Date: _____

V. FLEXIBLE SPENDING ACCOUNT (FSA) PLAN COVERAGE

EMPLOYEES WHO PARTICIPATE IN THE FSA PLAN MUST INITIAL BELOW.

I understand that under the terms of the FSA plan my coverage will continue for the remainder of the FSA plan year (i.e., until the following June 30th) even if my leave is unpaid. If I am on a paid leave of absence, the amount that I have elected to contribute to the FSA will continue to be deducted from my pay through payroll deduction during the portion of my leave that is paid. If I am on an unpaid leave of absence, I must submit payments for FSA plan coverage on or before the first day of each month. However, if I am on an unpaid FMLA leave, I understand that I may be able to change my FSA options by contacting the FSA plan administrator. A failure to make a monthly contribution will terminate my FSA plan coverage and I will no longer be eligible to submit reimbursements for claims incurred after the termination of my coverage. If coverage is terminated early due to my failure to timely pay FSA premiums, I understand that my FSA coverage will not be reinstated upon my return from a leave of absence (unless my entire leave was covered under the FMLA) and any unused FSA balance in my account will be forfeited.

Employee's Initials: _____ Date: _____

VI. CERTIFICATION

I certify that this information is correct, that I shall review and abide by the FMLA Policy and the Guidelines on Leaves of Absence. I intend to return to work after the expiration of any leave that may be granted to me based on this request for time off work. I understand that an employee's return from an FMLA leave will be governed by FMLA. With regard to all other leaves, I understand that if I properly return from a leave within six months, I may be assigned to the position I held prior to that leave if it is vacant and the employer decides to fill it. Unless otherwise prohibited by law, if I fail to report for work upon the expiration of my leave of absence and have not secured an approved leave extension in advance, I will be terminated from my employment.

Employee Signature: _____ Date: _____

Company Response (for non-FMLA leaves only) (See Designation Notice on p. 3 for FMLA Leaves):

√ One	Request ☐ conditionally granted ☐ granted. Dates and times of leave:_____
√ One	A Fitness for Duty Certificate will ☐ will not ☐ be required upon return to work.
√ One	☐ Request is denied for the following reason:
√ One	Leave is with pay ☐ Leave is without pay ☐ If pay covers only part of the leave of absence, it is with pay from _____ to _____

Date:_____ _____

(Signature of Company Representative)

***PLEASE CONSULT THE FMLA POLICY, GUIDELINES ON LEAVES OF ABSENCE, OR CONTACT YOUR HUMAN RESOURCES DIRECTOR OR APPROPRIATE ADMINISTRATOR FOR FMLA ELIGIBILITY REQUIREMENTS AND FOR ADDITIONAL INFORMATION CONCERNING OTHER LEAVES OF ABSENCE.**

Designation Notice
(Family and Medical Leave Act)

TO: _____ **DATE:** _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your recent information on _____and decided:

☐ Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended or were initially unknown. Based on the information you have provided to date; we are providing the following information about the amount of time that will be counted against your leave entitlement:

☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days or weeks that will be counted against your leave entitlement _____.

☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

☐ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

☐ You ☐ are ☐ are not eligible to use sick days for this FMLA leave. Based on your FMLA absence, you are eligible to use _____ sick paid days and if applicable _____ vacation paid days during your FMLA absence. (Per Archdiocesan Policy a maximum of 10 sick days per calendar year may be used for the purpose of care for a child, parent or spouse's illness.)

☐ We are requiring you to substitute or use paid leave during your FMLA leave.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☐ is ☐ is not attached. If attached, the fitness-for-duty certificate must address your ability to perform these functions.

☐ Additional information is needed to determine if your FMLA leave request can be approved:

☐ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.
Specify information needed to complete certification: _____
_____

☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

☐ Your FMLA Leave request is Not Approved

☐ The FMLA does not apply to your leave request.

☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

_____ _____
Signature of Company Representative Date