**Leave of Absence Request (CVGE3002)**

**Name/Job Title of Employee (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Request is made for leave of absence as indicated below:**

Employees MUST/MAY use any accrued unused time off before taking an unpaid leave of absence.

**INDICATE ALL TYPES OF LEAVE THAT APPLY**

Complete this form if you are requesting a 2 weeks of FFSL leave, a modified work schedule or intermittent leave under Family First Sick Leave (FFSL) and if you are requesting Family First Family Medical Leave Act (FFFMLA). Family First Sick Leave (FFSL) will only apply if leave is for an eligible reason (see below). NOTE: As needed, unpredictable intermittent leave is not available with Family First Sick Leave

**Leave Start Date Leave End Date (Est)**

**Total Leave Request, Start and End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Indicate the qualifying reason for the leave:**

1. \_\_\_ Subject to self-quarantine/isolation, state or federal mandate related to COVID-19
2. \_\_\_ Advised to by health care provider to self-quarantine due to related to COVID-19
3. \_\_\_ Experiencing COVID-19 symptoms and seeking medical assistance
4. \_\_\_ Caring for individual subject to criteria in #1 or #2 above
5. \_\_\_ Child Care required due to School or childcare closure elated to COVID-19
6. \_\_\_ Experiencing similar condition as specified by the Secretary of HHS

PLEASE NOTE: Once Family First Sick Leave begins, it must be taken in full day increments, and continue uninterrupted until such time the reason for the qualifying leave has ended. Employees who do not telecommute must take leave in full day and can not be taken intermittently for any othe reason above number 1 through 4 or 6.

**REDUCED WORK SCHEDULE:**

If the reason for the leave is school / childcare closure, please indicate below your requested leave schedule. HR will contact you to discuss options aviable for the requested leave. A reduced work schedule is not requreid, however if possible, efforts will be made to provide maixum flexibility. The employee and employer must mutally agree to the requested schedule.

Telecommuting employees may request a reduced work/intermittent leave work schedule for any quailify Family First qualify reason.The employer is not required to provide a reduced work schedule or intermentent Family First Sick leave for telecommuting employees, however, the employer and the employee must mutally agree to the requested schedule.

Days Per Week Requested Off: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reduced Work Hours Per Day, Requested Off, be as specific: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please indicated if there is additional leave or leave benefits being requested at this time? All additional leave will run POST exhaustion of Family First Sick Leave for any qualifying Family First event.

**Leave Start Date Leave End Date (Est)**

* Sick Leave – Company Policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Paid Time Off or Vacation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medical Leave, Self\_\_\_ or Family\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FMLA\_\_\_ ADA \_\_\_

* Pregnancy Disability Leave \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Baby Bonding – (for Parent/Spouse) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Personal Leave - Company Specific \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medical Leave - Company Specific \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Workers’ Compensation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I would like to request all accrued unused leave be paid during this leave period, including to supplement alternative leave compensation, to equal my full daily, weekly wage: Yes\_\_\_\_ NO \_\_\_\_**

**Additionally, I would like to request a draw against un-accrued PTO/vacation/sick of \_\_\_\_ Days [CUSTOMIZE TO IN ACCORDANCE WITH YOUR POLICY MANUAL]:**

|  |
| --- |
| **State purpose of leave below (do not disclose confidential medical information if leave is for a medical condition)** |

**My signature below confirms the following:**

* I understand that the leave, if granted, may be used only for the purpose described above and use of leave for any other purpose will be grounds for disciplinary action, up to and including termination.
* In the event an agreement is reached regrding a reasonable reduced work / intermitment leave schedule, I understand and confirm it is the my responsibly to maintain the agreed upon schedule.
* The expiration date of my Leave of Absence is the date I am expected to return to work (whether telecommuting or at my normal worksite). A request for extension of Leave of Absence should be made in writing, using this form, 2 days [VERIFY HOW MANY DAYS PER POLICY] before the end of my leave. I understand that I am responsible for maintaining contact with COMPANY regarding my return to work date. In the event, I will not be returning to work on the date listed above I must provide 24 hours notice, when possible, and provide appropriate ongoing certification(s), if applicable. Listed below is my address and telephone number where I may be contacted.
* **I acknowledge I am responsible for providing ongoing medical documentation confirming the need for leave if the leave is for medical reasons**. **I am required to provide a Release to Return to Work from my healthcare provider before returning to work**. [VERIFY POLICY MANUAL REQUIRMENTS]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employee Phone Number Date

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact [VERIFY NAME/EMAILOF PERSON TO RECEIVE FORM] when this form is complete.**

**To Be Completed By Human Resources**

Human Resources Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | * This Leave may qualify for Family First FMLA and/or ADA or Family   First Sick benefits: YES\*\_\_\_\_ NO\_\_\_\_ | | * This leave requires a medical certificate from the healthcare provider: YES \_\_\_\_ NO\_\_\_\_ | | * Certification from the healthcare provider is attached: YES \_\_\_\_ NO\_\_\_\_ | | * This leave requires a Family First Sick Leave Certificate: YES \_\_\_\_ NO\_\_\_\_ * Supervisor/Employee notified in writing that medical certificate required: YES \_\_\_\_ NO\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  Human Resources Signature Date | |  | |  | |

**\* HUMAN RESOURCES [VERIFY WHO] should expedite appropriate Family First FMLA Certification or other related leave certificates if required, maintaining confidentiality of all related medical leave records.**