Leave of Absence Request Form (LOA)

(Return form to your supervisor once complete)

Employee Name: _____ Employee ID#: _____

Leave Begin Date: _____ Leave End Date *(if known)***: _____**

Type of Leave Requesting

FMLA: ____ MRH Sponsored Medical Leave (employee only): ____ TN Maternity Leave: ____

Personal Leave (Medical): ____-Medical Certification Required

Personal Leave (Personal): ____-Written Request Required

USERA (Uniformed Services Leave): ____ -You must attach a copy of Military Orders

FMLA Requests only:

(Who are you caring for)

Your own medical condition: ____ Family member medical condition: ____ Birth/Adoption of child: ____

Spouse/parent/child of a covered service member on active duty: ____

Spouse/parent/child of an injured covered service member: ____

FMLA Eligibility and Determination Notice: You will receive a notice, by mail, informing you whether your leave has been approved and the amount of leave approved or explaining why you are not eligible to receive FMLA.

EMPLOYEES RESPONSIBILITES

- *I acknowledge, I have **15 calendar days**, from the date the LOA Packet is obtained, to submit completed documentation to the Human Resources Benefits Department.*
- *I acknowledge, any available PTO must be used during the elimination period for Short Term Disability, if eligible. Please refer to the included form "How to submit a STD claim."*
- *I acknowledge, I am responsible for providing adequate documentation (Physicians note, etc..) regarding an extension of leave and/or a tentative return to work date within 48 hours of being advised.*
- *I acknowledge, I am responsible for notifying my Supervisor/Manager at least one week prior to my return-to-work date to discuss my schedule.*
- *I acknowledge, I am responsible for submitting a return-to-work form, signed by my Physician, to the Human Resources Benefits Department at least one day prior to my return-to-work date.*
- *I acknowledge, upon return to work, in compliance with T.C.A 50-2-110, I authorize MRH to deduct from my pay twice the amount of the regular deductions for my benefit premiums. This deduction will continue until I have reimbursed MRH for all my benefit premiums accrued during my LOA.*
- *Written notice will be provided to you by mail, 14 days prior to the initial missed insurance premium deduction which will include the amount owed and date in which the deductions will start.*
- *I acknowledge, if separation from employment to MRH, any remaining owed premiums, will be sent to our collection agency within 30 days of termination date.*

I have read this form and understand my responsibilities as listed above. I understand final approval/designation of my leave request is contingent upon review of completed, appropriate documentation.

Employee Signature: _____ Date: _____

Supervisor/Manager Name: _____ Date: _____

Supervisor/Manager Signature: _____ Date: _____

For Human Resources Benefits Use Only

Has employee been employed 12 months within the last 7 years at MRH: YES / NO Has employee worked at least 1250 hours within the last 12 month: YES / NO

Employee FTE: FT / PT / 3DWE / WE/ FSSM / PRN Total amount of hours worked in 12 months prior to leave request: _____

Total used FMLA in 12 months preceding the begin date of this request (do not answer if USERA): _____ Total remaining FMLA days/weeks: _____