Leave of Absence Request Form

☒ New ☐ Amended

Please complete and submit this form to LeaveRequest@slcgov.com **30 days in advance of leave if possible.**

EMPLOYEE INFORMATION

Employee Name	**6 Digit Employee#**	**Date of Hire**
Home Address (street, city, state, zip code)	**Email (personal)**	**Phone# (personal)**
Job Title	**Work Schedule/Regular Days Off** (ex. M-F 8am-5pm/ Sat. Sun)	
Supervisor Name	**Department Name**	**Platoon (fire ONLY)** ☐ A ☐ B ☐ C

ABSENCE INFORMATION

Leave Type Request

Please indicate the applicable reason(s) for your leave below:

☐ To Care for My Own Medical Condition (**not work related**) ☐ WC **(work related injury)**

☐ Care for Parent, Spouse, or Child (please indicate): _____ (*father, mother, son, daughter, etc.).*

☐ Child Bonding (Care for Newborn/Adoption/Foster Care)

☐ Qualifying Military Exigency ☐ Care for service member ☐ USERRA: Military Leave

My request will be for the following basis: ☐ Continuous Leave ☐ Intermittent Leave

Last Date Worked (if applicable): _____ **Requested Start Date:** _____

Anticipated End Date: _____ *If Intermittent leave, no last date worked nor return date will be required.*

BENEFITS

I will file a claim for: ☐ Short Term Disability ☐ Parental Leave ☐ Plan A ☐ Workers Compensation

LEAVE HOURS RESERVE

☐ If your leave is approved under the FMLA, you may request to reserve up to **80 hours of time.** Please indicate the time you would like to reserve _____ hours of Vacation,and/or _____ hours of Personal leave.

Until your leave is appproved, you will be required to use some form of pay time off. Upon approval,your time will be adjusted.

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand the misrepresentation or omission of the reason for the leave or any of the facts supporting the need for leave may result in denial of the leave.

_____ _____

Employee Signature **Date**

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EMPLOYEE LEAVE OBLIGATIONS

If my leave request is for FMLA leave, and if I am approved for a FMLA leave, I acknowledge the following:

- I am required to provide the Certification of Health Care Provider for my own or my family member's serious health condition or other requested documentation.

- For a continuous leave which is eligible for supplemental pay (disability, worker's compensation, etc.), I will be required to use available and accrued time off to satisfy any applicable waiting period.

- I acknowledge that I will be allowed to reserve vacation and/or personal leave, not to exceed a combined total of 80 hours, by submitting a written request to LeaveRequest@slcgov.com. This request must be submitted prior to the first usage of accruals during the FMLA leave and one change to the request may be made during the leave.

- If my leave is intermittent and/or involves a reduced schedule, I must provide the Intermittent Tracking Sheet by the close of each pay period. The approved tracking sheet should be emailed to LeaveRequest@slcgov.com.

- While on leave, if I elect to continue my health insurance coverage, I am required to continue to contribute my share of the health insurance premiums. If I am in an unpaid status, I must contact Kate Blackwood (801-535-6303) to arrange payment of health insurance premiums. If payment is not received within 30 days, health insurance will terminate, and a COBRA packet will be mailed out.

- If I take continuous leave because of my own serious health condition, I am required to present a Physician's Return to Work Release note specific to my department before I may be restored to employment. Please provide to LeaveRequest@slcgov.com.

- If circumstances of my leave change and I am able to return to work earlier than the date originally indicated, I will be required to notify my supervisor and LeaveRequest@slcgov.com at least 2 business days prior to the date originally identified to report to work.

- I understand that I will not accrue sick or vacation hours while out on an unpaid leave.