

APPLICATION FOR FAMILY AND MEDICAL LEAVE OF ABSENCE

Name

Soc. Sec. #

Current Address

Length of Proposed Leave of Absence

Start - First Day of Anticipated Leave of Absence

Return - Date of Anticipated Return of Work

Reason for Requested Leave (Explain in detail and attach an additional sheet if necessary)

Name of Medical Care Provider (if applicable)

Phone Number of Medical Care Provider (if applicable)

Return all completed forms to:

**Employee Benefits Department
708 Blair Mill Road
Willow Grove PA 19090-1784
Attn: Bethany Mira**

In requesting this Leave of Absence, and should my request be granted, I agree as follows:

1. That if the reason for requesting a leave of absence is my own serious health condition, I agree that I will provide a satisfactory written medical certification to the company from my medical care provider which states (1) the date on which the serious medical condition commenced; (2) the probable duration of the condition; (3) the appropriate medical facts regarding the condition; (4) a declaration that I am unable to perform one or more of the essential functions of my position;

2. That if the reason for requesting a leave of absence is the serious health condition of my spouse, child, or parent, I agree that I will provide a satisfactory written medical certification to the company from the appropriate medical care provider which states (1) the date on which the serious medical condition commenced; (2) the probable duration of the condition; (3) the appropriate medical facts regarding the condition; (4) a certification that I am needed to take care of my spouse, child, or parent or provide psychological comfort; and (5) an estimate of the amount of time I will provide care for my spouse, child, or parent;

3. I agree that I will not accept or perform any work or engage in any employment during the proposed leave of absence, and if I do, I acknowledge that in such circumstances my conduct will be deemed to be a violation of the terms of the leave of absence, and that my employment with the company will be considered to have been terminated voluntarily on my part;

4. I understand and agree that any change in my condition during the leave of absence (if it should be granted) must be reported to the company within two (2) business days, and that a failure on my part to do so may result in the termination of the leave of absence or my employment;

5. I understand and agree that once my condition is such that I am able to work, I must furnish the company with a written certification from my medical care provider which certifies my ability to return to active employment;

6. I understand and agree that if my request for proposed leave of absence is granted, the company will make reasonable efforts to place me in my former job position and at my former rate of pay after the expiration of my proposed leave of absence, but that I have no right or guarantee that I will be reinstated to my former job position. I further understand that if my former position is not available, the company may place me in a different position that is equivalent to my former position.

7. I understand and agree that if I am considered a "key" or "highly paid" employee of the company (as defined by law or regulation), there may be circumstances where I may be denied reinstatement if it would cause "substantial and grievous economic injury" to the operations of the company. Therefore, in such circumstances, I understand and acknowledge that my employment with the company may be terminated;

8. I understand and agree that the company's policy provides that no leave of absence shall be longer than 12 weeks (or other period if specified by local law);

9. I understand and agree that if I have not returned to active employment within 12 weeks after the granting of my request for proposed leave of absence, my employment with the company will be considered to have been voluntarily terminated.

10. I understand and agree, that unless notified otherwise, the company will continue to provide any health care coverage I have in effect during my absence, and that I will pay any employee portion of the health care, dental and or vision premium that normally would have been deducted from my pay. It is understood I will be notified of the payment amount due and the date it is due by the company's Benefits Department in a separate letter. I understand and agree that if I do not return to work after leave, that I owe the company portion and any unpaid employee portion of the health care, dental and or vision premium that the company paid for me during my leave. I authorize the company to deduct this from any vacation pay, sick pay or other pay I would be entitled to upon separation from the company. If these are insufficient, I agree to make payment to the company for the balance due.

11. I understand and agree that the company will continue any group life insurance or disability benefits in which I am participant during my absence and any employee contribution I normally would have made will be deducted from my first pay check when I return to work. If I do not return to work, I acknowledge that I owe the full amount of the premium and agree the company may deduct the entire amount from any vacation pay, sick pay, or other pay I would be entitled to upon my separation from the company. If these are not sufficient, I agree to make payment to the company for the balance.

12. I understand and agree that before taking unpaid leave under the FMLA; I must use any accrued vacation time. This vacation time will be counted as part of the FMLA leave.

13. In the case of my own serious medical condition, I understand and agree that before taking unpaid leave or vacation under the FMLA, I must use any current paid sick leave. This sick time is to be counted as part of the FMLA leave.

14. I understand and agree that if I do not return to work on the first day after the proposed leave of absence expires or on the first day after my medical care provider determines that I am able to return to work, my employment with the company will be considered to have been voluntarily terminated.

Employee's Name *(Please Print)*

Acknowledged by *(Please Print)*

Employee' s Signature

**Signature of Supervisor or
General Foreman**

Date

Date