APPLICATION FOR LEAVE OF ABSENCE

Please provide the mailing address or email address that you wish to receive the leave approval notice by completing the appropriate area below. If information is not provided, we will send the notification to the address on file.

Name **Last 5 of SSN# or EMPLID#** **Phone #**

Current Home Address

Alternate Address **or** **Email Address**

Length of Proposed Leave of Absence

Start - First Day of Anticipated Leave of Absence

Return - Date of Anticipated Return of Work

Please provide type of leave being requested and brief reason to explain your need for leave (If requesting Intermittent Leave and expected leave schedule is known, please provide details and attach 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
PO Box 538
Willow Grove PA 19090-1784

or fax to:
Fax # (215) 784-1385

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 (which includes biological, adopted, or foster child, a legal ward, or a child of a person standing *in loco parentis*. FMLA regulations define employees standing *in loco parentis* as those with day-to-day responsibilities to care for and/or financially support a child. The employee will be required to provide reasonable *in loco parentis* relationship documentation) , 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. That if the reason for requesting a leave of absence is to care for a covered service member with a serious health condition who is a spouse, son or daughter, parent or who is designated as next of kin, 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 son or daughter, parent or who is designated as next of kin or provide psychological comfort; and (5) an estimate of the amount of time I will provide care for my son or daughter, parent or who is designated as next of kin;

4. That if the reason for requesting a leave of absence is for a Qualifying Exigency Leave for a spouse, son, daughter, parent on active duty or called to active duty status in the National Guard or Reserves in support of a contingency, I agree that I will provide the applicable form for “Certification of Qualifying Exigency” as well as written documentation confirming a covered military member’s active duty or call to active duty status in support of a contingency operation;

5. 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 unless otherwise required as a reasonable accommodation under the Americans with Disabilities Act (ADA);

6. 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;

7. 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;

8. 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.

9. 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;

10. I understand and agree that the company’s policy provides that no leave of absence shall be longer than 12 weeks (26 weeks to care for a covered service member with a serious injury or illness or other period if specified by local law);

11. I understand and agree that if I have not returned to active employment within 12 weeks (26 weeks to care for covered service member with a serious injury or illness), or longer period allowed under applicable state statute if greater than 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 unless an approved leave of absence extension has been granted.

12. 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, vision, premium that normally would have been deducted from my pay. During any portion of the leave that is unpaid, I understand that I will be required to make my portion of the premium payments for the continued health benefit coverage. It is understood I will be notified of the payment amount due and the date it is due as outlined in the attached “Notice of Eligibility and Rights and Responsibilities” form. Failure to make the required premium payments will result in cancellation of benefits from the date the last premium payment was paid.

13. I understand and agree that before taking unpaid leave under FMLA; I must use any available paid time accrued including, but not limited to vacation accrual, sick leave, excused absence time, PTO, etc.. All paid time off runs concurrently with leave and is not intended to extend the length 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 unless a personal leave extension is available under a CBA and has been approved by all parties prior to the end of the FMLA leave or for any leave period pursuant to state statutes that provides a greater benefit than the 12 work weeks or unless otherwise required as a reasonable accommodation under the Americans with Disabilities Act (ADA).

.

Employee’s Name (*Please Print*)

Employee’s Signature

Date