LEAVE OF ABSENCE (INITIAL OR EXTENSION) REQUEST

Employee Name__________________________________ **Position**______________________

Supervisor_______________________________________ **Location**_____________________

Last Day Worked___________________

Leave of Absence (Circle either Initial or Extension) to Begin on ______________________

and conclude on__________________

Available Leave Hours: **Sick/Personal**________ **Vacation** __________

Reason for Request (Check where applicable):

____ **Personal**
____ **Medical (attach a physician's statement or other supportive evidence)**
____ **Military**
____ **Other** ____

I have read and understand the Agency's policy regarding the type of Leave of Absence checked above. If I am unavailable to work at the conclusion of my (initial) leave, I understand it is my responsibility to contact my supervisor in advance, and if necessary, request an extension to my leave. I also understand that if neither my position nor a comparable position is available at the time I am available to return, I may be placed on lay-off status. I further understand that upon approval of this Leave of Absence, I must make arrangements for continuing my benefits. Failure to do so will terminate coverage.

____
Employee's Signature **Date**

Approvals:

Supervisor: (Check whether the Leave of Absence request is recommended or not and sign)

____ **Recommended**
____ **Not Recommended (with reason ____)**

Supervisor's Signature:____**Date**______________

Division Director's Approval Signature:__________________________**Date**_____________
Associate Director's Approval Signature:_________________________ **Date**_____________
HR Director Initial _____

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CONTINUATION OF BENEFITS WHILE ON A LEAVE OF ABSENCE or FMLA

Name of Employee________________________________
Program Location_________________________________
Dates of Leave: From_________________ Through _______________

Arrangements regarding continuation of your benefits must be made *prior* to the beginning of your leave of absence.

Type of Insurance	Type of Coverage	Cost
Health	**Individual ____**	**___________per_________**
	Employee + 1____	**___________per_________**
	Employee + 2____	**___________per_________**
Dental	**Individual ____**	**___________per_________**
	Employee + 1 ____	**___________per_________**
	Employee + 2 ____	**___________per_________**
Other____________	**________________**	**_______________________**

Please check below all that apply:

____ I wish to maintain the benefits checked above while I am on a LOA.

You are expected to pay Catholic Charities at the beginning of each month by sending in a check made out to Catholic Charities to the attention of the Human Resources Director. If extenuating circumstances prevent you from doing this, please contact the HR Director.

____ I do not wish to continue my medical benefits listed above.

Employee Signature **Date**

____

Program Administrator Signature **Date**

Human Resources Director Signature **Date**

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