HONORHEALTH

Leave of Absence Request

For Medical, Maternity, Family or Military

Information

Leave of Absence
Leave of absence is used to document and authorize time away from work for surgery, in-patient admission, or in excess of seven calendar days for medical leave or family care leave. This includes the need for intermittent and reduced-schedule.

Family Medical Leave Act
The Family Medical Leave Act (FMLA) gives an eligible staff member the right to take up to 12 weeks of unpaid job-protected leave in a 12-month period. Leave can be for the birth/adoption of a child, to care for a spouse, parent, or child with a serious health condition; or when the staff member is unable to work because of their own serious health condition. In addition, an eligible staff member may take up to 26 weeks of unpaid job-protected leave for military caregiver leave.

To be eligible, a staff member must complete 12-months of employment and have worked at least 1,250 hours during the 12-months immediately before the start of the leave.

The FMLA entitlement is determined by a rolling 12-month period measured backwards from the date a staff member uses family leave or medical leave.

FMLA runs concurrently with any paid leave offered by HonorHealth such as Paid Time Off (PTO), Short-Term Disability (STD), Workers' Compensation (WC). All days away from work (including intermittent absences, reduced schedule leave) will be counted toward the staff member's FMLA entitlement.

Periodic Reporting Requirements
While on leave, you may be required to furnish Employee Benefits with periodic written reports of your status and intent to return to work.

A Medical Certification is required to support a staff member's medical leave and must be completed by a physician. Family medical, intermittent and reduced schedule requires Certification of Serious Health Condition from Health Care Provider.

Return to Work
If your medical (including maternity) condition keeps you off work more than 7 calendar days, you must take a copy of the written release from your treating physician to Corporate Health for drug testing and final clearance to return to work. The urine drug test may be conducted up to 14 days prior to your scheduled return to work date. We recommend allowing sufficient time to be cleared by Corporate Health.

Return to work from a family (other than maternity), military or personal leave does not require a urine drug screen.

Question & Answer

1) How do I apply for a Leave of Absence?
   Complete a Leave of Absence Request and Authorization to Release Information (if applicable). Submit forms immediately to Employee Benefits. Then, have the appropriate medical certification completed by the treating physician. It is your responsibility to ensure that Employee Benefits receives all completed forms. DO NOT SUBMIT COMPLETED FORMS TO YOUR DEPARTMENT.

2) What happens after I submit my request?
   You will receive a letter letting you know whether you are eligible for leave under the FMLA and whether your absences qualifies as job-protected leave under the FMLA.

3) Will I be paid during my leave?
   While on medical leave:
   - PTO may be used to supplement payment of STD benefits which are processed by Mutual of Omaha. However, the combined total of STD and PTO may not exceed 100% of regular wages. You are responsible for notifying your department Manager/Supervisor so supplemental PTO can be entered on your timecard for payment.
   - WC payments will be paid through HonorHealth's claim administrator and PTO cannot be used.

   While on a family (including maternity), personal or educational leave:
   - PTO will be used and the amount of PTO used must be the same as normal scheduled work hours.

   While on military leave:
   - See policy HR1077 Military Deployment and Vaccines for Military Personnel.

4) Is my job protected?
   If you are not eligible for job-protected leave under the FMLA, your position may be posted and filled. If you are eligible for FMLA, your job is protected during the first cumulative 12-week period while you are on a qualifying FMLA leave. If you remain off work beyond 12 weeks, your position may be filled permanently. Please discuss the status of your position with your department manager.

   If your position is not available when you are cleared to return to work, you may have up to 30 days to work with Recruiting to find another position for which you qualify. If a position is not secured within 30 calendar days, your employment with HonorHealth will be separated.

5) How will my HonorHealth group health insurance premiums be paid?
   When you are not receiving a paycheck from HonorHealth you will be responsible for the cost of benefit premiums. You will receive instructions on how to pay your premiums in a separate letter. Premiums you pay will be based on your years of service:
   - More than one year of service – you will be responsible for the benefit premiums normally deducted from your payroll checks for you (and your dependents) for a maximum period of 6 months.
   - Less than one year of service, you will be responsible for the total cost of benefit premiums when your leave extends beyond two unpaid pay periods.

SEE POLICIES HR1032 (LEAVE OF ABSENCE) & HR1073 (FAMILY MEDICAL LEAVE (FMLA)) FOR ADDITIONAL DETAILS

HONORHEALTH

LEAVE OF ABSENCE REQUEST

For Medical Leave or Family Care Leave

Instructions – (1) This form should be completed by the staff member (or their designated personal representative) and returned to Employee Benefits as soon as possible. (2) It is the staff member's responsibility to ensure that Employee Benefits receives <u>all</u> required completed forms. DO NOT RETURN COMPLETED FORMS TO YOUR DEPARTMENT.

SECTION 1 – EMPLOYEE INFORMATION

Name (printed) _____ Employee # _____

Address _____ City _____ State _____ Zip Code _____

Wk Phone _____ Hm Phone _____ Cell Phone _____

May we communicate with you using your personal email? ☐No ☐Yes

Email: _____

SECTION 2 – JOB INFORMATION

Dept Mgr Ext Dept Supervisor Ext

SECTION 3 – REASON FOR REQUESTING LEAVE

I am requesting leave for the following reason:

☐ My own health condition – provide dates below(if applicable) Is the condition work related: Yes ☐ No ☐
Date of surgery/illness: _____ Date of in-patient admission _____

☐ Birth of my child; to care for my newborn child: Anticipated due date: _____
Do you plan to be off ☐ 6 weeks or ☐ 12 weeks?

☐ Placement of a child with me for adoption or foster care

☐ Care for a family member with a serious health condition
Relationship of family member to me: _____

☐ Military

☐ Qualifying exigency because family member is on active duty or has been called to active duty
Relationship of family member to me: _____

☐ Care for a family member who is a member of the Armed Forces and is undergoing medical treatment or recuperating from a serious injury or illness incurred while on active duty

SECTION 4 – DURATION OF LEAVE – DATES ARE REQUIRED TO BE PROVIDED

Date Leave Expected to Begin: _____ Date Leave Expected to End: _____

Will this leave be for a continuous period or intermittently? ☐Continuous ☐Intermittently/Reduced Schedule

If intermittent or reduced-leave schedule, please provide the estimated duration of scheduled leave:

SECTION 5 – SIGNATURE

I understand that all leave and duration are based on the medical certifications provided by my doctor. Failure to comply with any policies or procedures associated with my leave may result in denial of my leave and/or termination of my employment. I further understand that it is my responsibility to provide supporting documentation to Employee Benefits upon request.

Staff Member Signature **X** _____ Date _____

Mail or fax completed documents to:
HonorHealth, Employee Benefits
8125 N Hayden Rd, Scottsdale, AZ 85258
Fax: (480) 882-5802 / Email:
employeebenefits@honorhealth.com

HONORHEALTH

Medical Certification

Instructions

The attending physician must complete this form. This form has been designed to be used for a staff member's absence from work when the staff member's own serious health condition makes him/her unable to perform his/her job. Intermittent absence and reduced schedule requires Certification of Serious Health Condition.

The HonorHealth staff member must be under the regular care of a physician who certifies that the staff member is disabled. The term physician means a person (other than you, your spouse, child, brother, sister or parent, or the child, brother, sister or parent of your spouse) who is properly licensed as a M.D., D.O., D.P.M., D.D.S., D.M.D, or Psychiatrist, and recognized by the state in which treatment is provided, and who is qualified to treat the condition or injury for which you are applying for benefits. Chiropractors and Acupuncturists are not covered.

Patient Information

Name (printed) _____ Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____ Phone _____

Physician Information

Physician Name _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Treatment Information

Is injury/illness work related? ☐ Yes ☐ No

Date Condition Began _____ Most Recent Treatment Date _____ Next Appointment Date _____

Date of Surgery _____ Date of Inpatient Hospitalization _____ Pregnancy Due Date _____

Primary Diagnosis _____

Subjective/Objective Findings _____

Treatment Plan (including type of surgery, prescribed medications, etc) _____

Work Status

☐ **Off work** beginning _____ (date), ending _____ (date)

☐ **Restricted work** beginning _____ date, ending _____ (date)

Restrictions

☐ Limit shift to _____ hours ☐ No reaching above shoulder level ☐ Limited use of _____

☐ No lifting over _____lbs ☐ No kneeling or squatting ☐ No use of _____

☐ No push/pull over _____ lbs of force ☐ No climbing stairs or ladders ☐ No bending of _____

☐ Should be sitting _____% of time ☐ Other _____

☐ **Return to work** with no restrictions, effective _____ (date)

Physician Signature **X** _____ Date _____

Mail or fax completed documents to:

HonorHealth, Disability Management
8125 N Hayden Rd, Scottsdale, AZ 85258-5199
Phone: (480) 323-4540, Fax: (480) 882-5802