HONORHEALTH

Leave of Absence Request

Military Duty, Qualifying Exigency for Military, Care for Military Service Member

Information

Leave of Absence

Leave of absence is used to authorize and document time away from work in excess of seven calendar days for military leave, to address certain qualifying exigencies and to provide care for a covered service member.

Staff Member Military Leave

See policy HR1077 Military Deployment and Vaccines for Military Personnel for more detailed information.

Military Family Medical Leave Entitlements under FMLA

Eligible staff members with a spouse, parent, son or daughter on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. These may include attending certain military events, arranging for alternative child care, addressing financial and/or legal matters and attending post-deployment reintegration sessions.

To be eligible for FMLA job protection, 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.

FMLA also includes a special leave entitlement that permits eligible staff members to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. The service member must have a serious health condition incurred in the line of duty on active duty that may render the service member medically unfit to perform his/her duties. For this leave the 12-month period is measured forward.

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.

Certification is required to support a qualifying exigency or to provide care to a covered service member who has been injured in the line of duty.

Return to Work

When returning to work, please contact Employee Benefits so your records can be updated accordingly.

Question & Answer

1) How do I apply for a Leave of Absence?
   Complete the appropriate leave of absence form and return them to Employee Benefits.

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 qualifying exigency leave or leave to care for service member:
   - PTO must be used and the amount of PTO used must be the same as your normal scheduled work hours.

4) Is my job protected?
   If you are not FMLA eligible, your position may be filled permanently.

   If you are FMLA eligible, your job is protected during the first cumulative 12-week (or 26 weeks for care of a service member) period while you are on a qualifying FMLA leave. If you remain off work beyond 12 weeks (or 26 weeks) your position may be filled permanently.

   If your position is not available upon return form leave, 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 12 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 POLICIY 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

Certification of Qualifying Exigency For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

_____
First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

CONTINUED ON NEXT PAGE

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

_____

_____

_____

_____

_____

_____

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. ☐ Yes ☐ No ☐ None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

   Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ No ☐ Yes.

   If so, estimate the beginning and ending dates for the period of absence:

   _____.

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ No ☐ Yes.

   Estimate schedule of leave, including the dates of any scheduled meetings or appointments:_____

   _____

   _____

   _____

   Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours ___ day(s) per event.

CONTINUED ON NEXT PAGE

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____)_____ Fax: (_____)_____

Email: _____

Describe nature of meeting: _____

_____

_____

_____

_____

_____

_____

_____

_____

PART D:

I certify that the information I provided above is true and correct.

_____ _____

Signature of Employee Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**