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**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 from 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.

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**SEE POLICY HR1073 (FAMILY MEDICAL LEAVE (FMLA)) FOR ADDITIONAL DETAILS**

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 all 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](mailto:employeebenefits@honorhealth.com)