Café #________

Leave of Absence Request

Name: ____ SSN: xxx - xx - ____________ (last four only)

Address: ____

Phone: (_______)_______-____________

Email: ____

I, ___________________________, am requesting a leave of absence for the following:

☐ Medical – *FMLA, PFL, STD – must have been employed for 1 year*

☐ Educational Leave – *time off request must be submitted, granted at the discretion of the company*

☐ Personal – *time off requests must be submitted – must have been employed for 1 year, granted at the discretion of the company*

☐ Workers Compensation – *must have a claim on file prior to taking leave*

LOA starting date: _____ /____ /____

Return to work date: _____ /____ /____

- It is the employee's responsibility to submit a fully completed Leave of Absence request form to their Supervisor/ Manager for signature who will then forward this form to the Human Resources department.
- I understand approval of leave is contingent upon timely submission of required documentation/certifications;
- I will return to work or request an extension of leave before the Expected Return Date shown above;
- Upon requesting a personal or educational leave, I will submit a time off request and exhaust my vacation time prior to taking an unpaid leave.
- I understand that during a leave of absence, I will not accrue any vacation time;
- If the request exceeds the allowed time limit or approved period of leave, I must resign my position and re-apply for employment;
- If I request a personal or educational leave, my seniority date will be replaced with my first day back from leave;
- I understand my employment may be terminated if I fail to return to work or request a leave extension;
- I will provide my Supervisor with sufficient advance notice of my intent to return to work to allow for schedule planning;
- I will present to my Supervisor, a Release to Return to Work from my Provider verifying my ability to return to work from a medical leave form before returning to work;
- If my job is no longer available at the end of my leave, the company may return me to a comparable job.
- I understand that my position is subject to the same risks as an employee not taking a leave, such as reductions in force, job restructuring and job reassignments.
- I agree to pay any group insurance premium for which I am responsible.

____ _________________

Employee Date

Café #________

Birth, Adoption, or Foster Care

Expected date of birth:_________________________

If spouse/partner is Manna employee, what is their name and home department he/she is assigned to:

Expected date of physical custody of adopted/foster child: ____________________________________

Name and address of Agency responsible for adoption/foster care: (Provide certificate from agency):

You must provide a completed "Certification of Health Care Provider" from your treating Physician *and submit to HR*

Medical Care for Employee (Self)

Reason for Medical Leave (Optional):____

A general description is requested, but you are not required to disclose any private information. This information is requested solely to assist the company in accommodating your leave needs. Your medical information is kept confidential in the Employee Relations department and not at the home departmental level. **You must provide a completed "Certification of Health Care Provider" from your treating Physician *and submit to HR***

Family Member, Domestic Partner, or Military Caregiver Leave*

Name of Family Member/Military Member/Partner needing care:_____________________________________

Relationship to employee: Child, age ______ Spouse Parent Same Sex Domestic Partner

Next of Kin (for Military Member Leave Only) Other Under CSA (Relationship)____________________________

If this leave involves an intermittent or a reduced work schedule, please provide anticipated schedule:

** A spouse, child, parent, or next of kin may take up to 26 weeks of FMLA during a single 12-month period to care for a member of the Armed Forces including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness in the line of duty.*

You must provide a "Certification of Health Care Provider" from the treating Physician and submit to HR

Spouse, Child, or Parent Called to Military Active Duty

Name of Military Member:____________________________________

Military Operation: Southwest Asia/Iraq Afghanistan/ Other ____

Military Member Relationship to Employee: Spouse Child Parent

An employee can take up to 12 weeks of FMLA leave for any qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. This leave is not confined to a single 12-month period. The 12-weeks are also reduced by leave for any other qualifying FMLA event during the 12-month period.

Manna Development may require that your request for leave be supported by a Certification as prescribed by the U.S. Secretary of Labor.

Personal Leave

Reason for requested leave:

____

Maximum of 21 Days – if leave should exceed this the employee should resign and re-apply

***Expected Return Date:*____________________________**

Educational Leave

Current Job Title: _________________________________

Classes/Degree to be taken/earned while on Edu Leave: ____

***Expected Return Date:*____________________________**

Education Leave maximum up to 4 months – if leave should exceed this the employee should resign and re-apply

Verification of Enrollment Attached (required)

Supervisors to Complete – Please make sure form is completed before signing.