

[COMPANY]

**LEAVE OF ABSENCE APPROVAL/CONDITIONS**

Employee's Name: \_\_\_\_\_

Type(s) of Leave: \_\_\_\_\_

Leave Dates: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Your leave of absence is not approved because: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Your leave of absence is approved subject to the following terms and conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Leave Designation** (check all that will apply):

- |  |                                    |
|--|------------------------------------|
| _____ Federal Family and Medical leave (FMLA)    | _____ Sick leave                   |
| _____ California Family and Medical leave (CFRA) | _____ Vacation leave               |
| _____ Pregnancy Disability leave (FEHA)          | _____ Funeral or Bereavement leave |
| _____ Workers' Compensation leave                | _____ Jury Duty leave              |
| _____ Military leave                             | _____ Witness Duty leave           |
| _____ Personal leave                             |                                    |
| _____ Other _____                                |                                    |

You are entitled to 12 workweeks of family and medical leave in a 12-month period. Your 12-month period began/will begin on \_\_\_\_\_ (date).

**Compensation** (check all that will apply):

- \_\_\_\_\_ No compensation will be paid during the leave of absence.
- \_\_\_\_\_ All accrued vacation and other accrued paid time off (excluding sick leave ) MUST be taken.
- \_\_\_\_\_ All accrued vacation and any other accrued paid time off (excluding sick leave) MAY be taken. Please notify the Human Resources Department immediately if you elect to use your accrued vacation.
- \_\_\_\_\_ All accrued sick leave MUST be taken.
- \_\_\_\_\_ All accrued sick leave MAY be taken. Please notify the Human Resources Department immediately if you elect to use your accrued sick leave.
- \_\_\_\_\_ Other (specify): \_\_\_\_\_
- \_\_\_\_\_

**Medical Insurance**

\_\_\_\_\_ Group health insurance premiums will be paid by the Company, under the same conditions as existed prior to the leave, for a maximum period of twelve (12) workweeks in a twelve (12) month period. If you return within the twelve week period, your health insurance will continue upon your return to work.

\_\_\_\_\_ You must pay your share of the medical insurance premiums in order to continue your existing medical insurance coverage. Your payments are due \_\_\_\_\_.

\_\_\_\_\_ Group health insurance coverage will cease on \_\_\_\_\_ (date) except that continuation is allowed under [COBRA or Cal-COBRA] regulations if applicable to the plan. Upon return from a leave, you may resume health benefits in accordance with the provisions of the plan.

\_\_\_\_\_ If you fail to return to work at the expiration of FMLA/CFRA leave, you must repay any health insurance premiums paid by the Company while you were on leave, unless your failure to return to work is due to a continuation of your own serious health condition or other reasons beyond your control.

**Accruals:**

\_\_\_\_\_ Paid time off benefits (vacation and sick leave) will continue to accrue while you are on paid leave.

\_\_\_\_\_ Paid time off benefits (vacation and sick leave) will not accrue while you are on unpaid leave.

**Reinstatement:**

\_\_\_\_\_ You must provide a certificate from your physician regarding your fitness to return to work before you return to work.

\_\_\_\_\_ If applicable and return is timely, reinstatement will be made to the same or an equivalent position and pay rate to the extent required by law.

\_\_\_\_\_ No guarantees are made as to reinstatement to the same or an equivalent position and pay rate upon return from the leave.

\_\_\_\_\_ You are a "key" employee who will be denied reinstatement if you take leave (or fail to return to work) by \_\_\_\_\_ because substantial and grievous economic injury will result from your reinstatement as a result of \_\_\_\_\_

**Forfeiture:**

\_\_\_\_\_ If you accept employment or other compensation for services elsewhere while on leave, you will be considered to have voluntarily resigned as of the date other employment or compensation is accepted.

\_\_\_\_\_ If you fail to notify or return upon expiration of the leave, you may be considered a voluntary quit.

\_\_\_\_\_ Should you be otherwise subject to layoff had you been actively employed, you will be similarly subject to layoff while on leave.

**Extension:**

\_\_\_\_\_ Extension of this leave is not available.

\_\_\_\_\_ Extension of this leave is contingent upon recertification of the serious health condition.

\_\_\_\_\_ If an extension of this leave is needed, a written request should be submitted to Human Resources for approval as soon as you learn of the need for the leave extension. The extension may be on terms other than those set forth on this form.

**Other Conditions:** (Specify)

Your rights to this leave are protected by FMLA, CFRA, and/or FEHA, if this leave is designated as such. To the extent that any leave exceeds that which is required, this leave of absence does not constitute a contract of employment or reemployment. All leaves in excess of those which are required are subject to the policy that employment is for no fixed term and may be terminated, with or without cause or notice, at any time at the option of the employer or employee.

I have read and understand the foregoing conditions regarding my leave of absence.

\_\_\_\_\_

Date

\_\_\_\_\_

Employee

\_\_\_\_\_

Date

\_\_\_\_\_

Department Head

\_\_\_\_\_

Date

\_\_\_\_\_

Human Resources Director

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