

InformationLeave of Absence

Leave of absence is used to document and authorize time away from work for surgery, in-patient admission, or time away 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 rolling 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 your Employee Benefits department with periodic written reports of your status and intent to return to work.

Question & Answer

- 1) How do I apply for a Leave of Absence?
Complete the Leave of Absence Request form. Submit the request form immediately to your Employee Benefits department. Please 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 family 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 will be separated.
- 5) How will my 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.

SEE POLICIES HR1317 (LEAVE OF ABSENCE) & HR1311 (FAMILY MEDICAL LEAVE (FMLA)) FOR ADDITIONAL DETAILS



LEAVE OF ABSENCE REQUEST

Family or Military

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 this completed form. Please do not submit to your department.

SECTION 1 - EMPLOYEE INFORMATION

Name (printed) _____ Employee # _____
Address _____ City _____ State _____ Zip Code _____
Work # _____ Home # _____ Cell # _____

May we communicate with you using your personal email? [] No [] Yes
Email: _____

SECTION 2 - REASON FOR REQUESTING LEAVE

I am requesting leave for the following reason:

- [] Paternity-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 undergoing medical treatment or recuperating from a serious injury or illness incurred while on active duty

SECTION 3 - 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 [] Intermittent/Reduced Schedule

SECTION 4 - SIGNATURE

I understand that all leave and duration are based on the medical certifications (if applicable) provided by a physician. 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 the Employee Benefits department upon request.

Employee Signature X _____ Date _____

Submit document(s) to:
HonorHealth
8125 N. Hayden Road, Scottsdale, AZ 85258
Fax: (480) 882-5802
Email: employee.benefits@honorhealth.com