PARTNERS HEALTHCARE

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

LEAVE OF ABSENCE (LOA) REQUEST FORM

Family and Medical Leave Act (FMLA) Eligibility:

a.) Have you worked for PHS or an entity for at least 12 months? ____YES ____NO
b.) Have you worked at least 1250 hours for PHS (24 hours/week) in the last year? ____YES ____NO
c.) Have you taken a FMLA leave in the last 12 months? ____YES ____NO
If yes, please give details:

Types of Leaves

FMLA and ACTIVE Leaves of Absence – Your position or an equivalent position will be maintained as though you are actively working. To continue receiving pay you may apply for short-term disability (STD) benefits and use Paid Time Off (PTO) to supplement, if applicable. Your Earned Sick Leave (ESL) will be used only in conjunction with Short-Term Disability.

INACTIVE/NON-FMLA Leaves of Absence – Your supervisor is NOT required to hold your job and re-employment is not guaranteed for Non-FMLA and Inactive leaves.

Please Select One:

ACTIVE LEAVE

☐ Adoption/Foster Care (FMLA) ☐ Family Member Medical Care (FMLA)* ☐ Maternity (FMLA) (MMLA)
☐ Military (USERRA) ☐ Organ/Bone-Marrow Donor ☐ Paternity (FMLA)* ☐ Personal Medical Care (FMLA)*
☐ Military Family Leave – Qualifying Exigency (FMLA)**
☐ Military Family Leave – Military Caregiver (FMLA)*** (You may be eligible to apply for up to 26 weeks of job protected leave)

INACTIVE and Non-FMLA LEAVE

☐ Sick (non-FMLA)* ☐ Parental (non-FMLA) ☐ Personal (non-FMLA)

*** Medical documentation, in the form of the Health Care Provider Certification Form, is required for these leaves**
**** The Certification of Qualifying Exigency is required for this leave**
***** The Military Health Care Provider Certification Form is required for this leave**

☐ **Check if requesting an intermittent/reduced schedule leave (where absence from work is not continuous).**

☐ **Check if requesting to supplement your STD or Parental leave benefit with PTO (if applicable).**

Please Complete:

Employee Name: _____ Employee ID#: _____

Expected Date Out: _____ Expected Return Date: _____

Home Mailing Address: _____

Home Email Address: _____ Home Phone: _____

Please indicate your preferred method of receiving communications from the LOA Coordinator? ☐ Email ☐ Mail

Manager/Supervisor Name: _____ Department: _____

- I understand that I may be required to submit medical updates to remain on a leave of absence and there is no guarantee of re-employment following an INACTIVE or Non-FMLA Leave of Absence.
- I understand that if my leave requires the Health Care Provider Form, required if after the type of leave there is an asterisk(*), that my health care provider must submit the form to the PHS LOA Coordinator and I hereby authorize the PHS LOA Coordinator to receive that information.
- I grant PHS permission to contact my health care provider for clarification if necessary. I understand I may refuse to permit PHS to communicate directly with my healthcare provider and that I may be denied FMLA leave.
- I understand that I must make an appointment with Occupational Health Services (OHS) prior to returning from a Medical Leave and I must provide OHS with a written medical clearance from my healthcare provider.

_____ _____ _____
Employee Signature **Date** **Phone Number**

_____ _____ _____
Manager/Supervisor Signature **Date** **Phone Number**

Please have your supervisor sign this form and then fax to the Leave of Absence Coordinator at 617-726-1887 or send it electronically to LOPHS@partners.org. Questions? Please contact the Leave Coordinator at the above email or call 617-724-1066.

Last Updated: January 16, 2009