Prescott College

Leave of Absence Request Form

Employee Information

Name:	Date of Hire:
Title:	
Department:	Supervisor:

What is your requested leave time: **FROM:**_____ **TO:** _____ Estimated? ○ Y ○ N

Are you requesting Full-Time Leave?: ○ Yes ○ No

Are you requesting Intermittent or Reduced Schedule Leave?: ○ Yes ○ No

Have you taken a leave of absence under the Personal or FMLA Policy during the past twelve (12) months?:

○ Yes ○ No ○ Not Applicable If yes, when?:_____

Leave Information

☐ Check Type of Leave Requested and Documentation Required

☐ **Employee Medical Leave**

Nature of Serious Health Condition (check one or more):

○ **1. Hospital Care –** Inpatient care (i.e, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

○ **2. Absence Plus Treatment**
A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
a. Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider or health care services (e.g., physical therapist) under orders of, or on referral by a health care provider; or
b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervisor of the health care provider.

○ **3. Pregnancy –** Any period of incapacity due to pregnancy, or for prenatal care.

○ **4. Chronic Conditions Requiring Treatment –** A chronic condition which:
a. Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and:
c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

○ **5. Permanent/Long-Term Conditions Requiring Supervision–** A period of incapacity which is permanent or long- term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of , but need not to be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

○ **6. Multiple Treatments (Non-Chronic Conditions) –** Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

****** For this leave request: attach a Physician's Certificate that includes:***
Employee's name, inability to report to work due to medical condition, nature of condition, include anticipated time frame, or prognosis, and the physician's signature. ***

Leave Information (continued)

☐ **Family Leave**

○ **Medical**

➢ Attach Physician certificate for family member should state date when serious illness began, probably duration, estimate by provider of time employee needs to care for family member, and a statement that care by family member is warranted.

Name and relationship of family member:

_____ _____

Name Relationship

○ **Non-Medical Leave**

➢ Attach ○ Birth Certificate for Family Leave for Care of Newborn **OR**
○ Placement papers for Family Leave for Adoption/Foster Care

☐ **Military Leave**

➢ Attach ○ Orders for Entry into Military Service or call to Active Duty **OR** ○ Leave for Reserve/Civil Disaster/Riot Duty

☐ **Personal Leave**

➢ Provide reason as provided below for Personal Leave:

☐ **Administrative Leave**

➢ Provide reason as provided below for Administrative Leave:

Acknowledgement

I have read the Prescott College policy regarding leave of absence.

I certify that the above information is correct and understand that falsification or omission of pertinent facts may result in denial or termination of my leave, and/or disciplinary action up to and including termination of employment. I also agree to cooperate with the College in communicating my intentions for leave and return, as well as furnishing required documentation including meeting any College requests for a second/third medical opinion.

If you do not return to work following the expiration of an approved leave of absence, you will be considered to have voluntarily resigned.

I understand that a leave of absence or completion of this document does not insulate me from any employment related actions that began prior to this time period. This document does not assure continued employment with Prescott College. Prescott College is an at-will employer which means that either the employee or Prescott College can terminate the employment relationship at any time, with or without notice, with or without cause.

I have read, understand, and agree to the above information.

_____ _____

Employee Signature Date

○ Employee has met 12month/1250hour reqmt ○ physician certification rec'd ○ received on _____

Approvals

_____ _____

Supervisor **Date** **Human Resources** **Date**

_____

Dean **Date**

○ **Denied by** _____ **Reason for denial:** _____