DENVER HEALTH
Level One Care for ALL

LEAVE OF ABSENCE (LOA)Request Form

I HEREBY REQUEST A LEAVE OF ABSENCE FROM DENVER HEALTH

Section A: Employee Information

Employee Name (Last, First, MI):	SSN:	Hire Date: - -	
Street Address:	City:	State:	Zip Code:
Home E-mail Address (If no home e-mail address, then enter N/A);		Home/Cell Phone Number:	

Reason for Leave (Select only one):	***Complete:***
☐ Birth, Adoption, or Foster Care	Sections A & B
☐ Employee – Own Condition	Sections A & C
☐ Medical Care of Family/Military Member/Partner	Sections A & D
☐ Spouse/Child/Parent Called to Military Duty (FMLA)	Section A
☐ Personal Leave	Sections A & F
☐ Colorado Domestic Violence Leave	Sections A
☐ Educational Leave	Sections A & G
☐ Military Leave for Employee (Need Copy of Orders)	Section A
☐ Non-FML Medical Leave	Sections A & C

Supervisor: Is this a Workers' Comp Claim? ☐Yes ☐No

Dates of Requested Leave:

From _____ to _____
(Return Date Required)

FMLA Request is for:
☐ Continuous leave (one continuous period of time off)
☐ Intermittent leave (leave taken in separate periods of time due to single illness or injury)
☐ Reduced Schedule

Employee's FTE Status: ☐ *Intermittent Employee*
☐ 1.0/*40 hrs/wk* ☐ *0.9/36 hrs/wk* ☐ *0.8/32 hrs/wk*
☐ *0.7/28 hrs/wk* ☐ *0.6/24 hrs/wk* ☐ *0.5/20 hrs/wk*

Have you been on a LOA within the last 12 months: ☐ Yes ☐ No

Current Employer: ☐ CSA ☐ DHHA

I understand if my leave request is granted it will continue on the following conditions:

- 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 Employee Relations department. If the Request for LOA form is not fully completed, it will be returned to the employee to complete. This will delay providing the employee with the FMLA Eligibility Notice and subsequently the leave approval;
- I understand approval of leave is contingent upon timely submission of required documentation/certifications;
- I will provide my Supervisor with updates of my return to work status every thirty (30) days;
- I will return to work or request an extension of leave before the Expected Return Date shown above;
- 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 48 hours notice of my intent to return to work;
- 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 on Denver Health's standardized form before returning to work;
- I agree to pay any group insurance premium for which I am responsible;
- I have read and understand HR Employee Principle & Practice #5-106, Leave of Absence.

Employee's Signature:	Mail Code:	Date Signed:

Section B: Birth, Adoption, or Foster Care

Expected date of birth:_____

If spouse/partner is DHHA/CSA 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):

How many weeks of maternity leave are you requesting: ☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ Other: _____

You must provide a completed "Certification of Health Care Provider" from your treating Physician & return to the Employee Relations department via scanning to your DH email then forwarding to LOA FML Process in Outlook. Please request a read receipt.

Section C: Medical Care for Employee (Self)

Reason for Medical Leave (Optional):_____
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 & return to the Employee Relations department via scanning to your DH email then forwarding to LOA FML Process in Outlook. Please request a read receipt.

For CSA Employees: Contact the Denver Health Payroll department regarding Short-Term Disability (STD) claims.
For DHHA Employees: If eligible for STD, the Employee Relations dept will send forms with further instruction.

Section D: 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 & return to Employee Relations Dept.

Section E: 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.

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

Section F: Personal Leave

Reason for requested leave: _____

_____

Minimum of 21 Days - Maximum of 90 Days

Section G: Educational Leave

Current Job Title: _____

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

_____

_____

Expected Return Date:_____

Education Leave maximum up to 2 years

How will this education leave benefit Denver Health?

_____

_____

_____

☐ ***Verification of Enrollment Attached (required)***

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

Supervisor Name: (Please Print)	Supervisor Phone Number:	Supervisor Mail Code:
Supervisor Signature:	Date:	
Department Manager Signature:	Manager Name Printed:	Date:

For Employee Relations Department

CHRO / Designee (Education/Personal LOAs Only):	Date:

Comments:

_____

☐ STD Packet sent:

Supervisors keep a copy for your records. *07/20/2011*

Supervisors, please forward this form to the Employee Relations department by scanning to your DH email (via dept multifunction copier) and forwarding to LOAFMLProcess@dhha.org with a read receipt requested (preferred method) or fax to 303-602-4944.

If you have any questions on how to complete this form, please call the Employee Relations Department at 303-602-7007.