DENVER HEALTH
est. 1860
FOR LIFE'S JOURNEY

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
☐ Medical Care of Family/Military Member/Partner	Sections A & C
☐ Spouse/Child/Parent Called to Military Duty (FMLA)	Section A &D
☐ Personal Leave	Sections A & F
☐ Military Leave for Employee (Need Copy of Orders)	Section A

Dates of Requested Leave:

From _____ to _____
(Estimated Return Date)

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*

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

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

Current Employer: ☐ CSA ☐ DHHA

Employee's Signature:

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: _____

Section C: 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 D: 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

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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

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: _____	

Supervisors keep a copy for your records.

Supervisors, please forward this form to the Leave of Absence 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 Leave of Absence Department at 303-602-7007.