Leave of Absence Request Form
(Attachment A)

Vermont General Assembly
Office of Legislative Human Resources

A leave of absence is available in certain circumstances as described in the Vermont General Assembly's leaves of absence policies. Employees who meet the eligibility criteria for a planned leave of absence must complete this form at least 30 days prior to the commencement of leave or as soon as practicable in the event of an unforeseeable absence. Please note:

- All leaves of absence must be approved in advance by Human Resources (HR) and the employee's supervisor.
- If the dates of requested leave change, a new leave of absence request form must be submitted for approval.
- All approved leaves of absence are unpaid unless an employee can utilize accrued paid leave.
- Employees on an unpaid leave of absence are responsible for payment of insurance premiums, as governed by the State's applicable policies.
- Employees returning from a leave of absence must contact HR and their supervisor at least one week in advance of the projected return date, and documented medical clearance may be required in order to return.

See Policy #00001 (Parental and Medical Leaves of Absence) or Policy #00002 (Earned Sick Time) for details on leaves of absence, including eligibility.

SECTION 1 – REQUEST: *to be completed by the employee*

Date of Request: _____ Employee Name: _____

Office: _____ Job Title: _____

Date of Hire: _____ Scheduled Hrs./Wk.: _____

Anticipated Leave Dates *(mm/dd/yy):* _____ to _____, after which I intend to return to work. I will update the Office of Legislative Human Resources when confirmed dates are known.

Reason for the leave of absence:

- ☐ Personal Medical Leave*
- ☐ Family Member Medical Leave*
- ☐ Parental Leave*
- ☐ Leave for Crime Victims
- ☐ Pre-Eligibility Leave*
- ☐ Military Leave**
- ☐ This is a request to **change or extend** an existing, approved leave request.

***This leave request requires the completion of the PMLA section on pages 2 and 3 of this form, as well as a Certification of Health Care Provider Form (Attachment B); please attach.*
****Please attach military leave orders for this leave request, if available.*

SECTION 2 - **PARENTAL AND MEDICAL LEAVE (PMLA):** *to be completed by employee requesting a leave as described below*

Employees requesting leave that qualifies as Family Leave for an **employee's own** serious health condition or to care for a **Family Member** with a serious health condition or Parental Leave for the birth of their child, their medical condition due to their pregnancy, or the placement of a child with them for adoption must complete the following information.

1. I hereby request approval for a **Family or Parental Leave**. I expect that my need for leave during that period will be **(mark appropriate block)**:

- ☐ continuous
- ☐ intermittent **(please also complete Section 3 of this form)**
- ☐ reduced scheduled leave **(please also complete Section 3 of this form)**

2. I request **Family or Parental Leave** for the following reason (**mark the appropriate block**):

- ☐ the birth of my child, my medical condition due to my pregnancy, or the placement of a child with me for adoption
- ☐ a serious health condition that makes me unable to perform my job
- ☐ a serious health condition affecting my family member

3. I am aware that, if I am eligible under the applicable State and federal statutes, I have the right to:

- take up to 16 weeks of unpaid Parental Leave in a 12-month period or 12 weeks of unpaid Family Leave in a 12-month period; and
- use any accrued paid leave, including sick, annual, and personal leave and compensatory time, during such a leave, but that no combination of paid and unpaid leaves may extend the leave beyond the time allotted.

4. I am aware that this leave will count against my Parental or Family Leave entitlement under the Vermont Parental and Family Leave Act, 21 V.S.A. § 470 et seq., in circumstances where I qualify for leave under those statutes.

5. I am aware that I must furnish medical certification of any serious health condition that is the basis for my leave request, and that I may be required to provide re-certification as reasonably requested by my employer.

- ☐ Certification of Health Care Provider form (Attachment B) is enclosed with this request.

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SECTION 3 – INTERMITTENT / REDUCED SCHEDULE: *to be completed if an employee is requesting Intermittent or Reduced Schedule Leave*

This section must be completed if an employee is requesting **Intermittent or Reduced Schedule Leave**. Please note the following:

- An employee who qualifies for Family Leave may, if medically necessary, take leave on an intermittent basis or in the form of a reduced schedule.
- For an employee who qualifies for Parental Leave after the birth or placement of a child, the employer, in its discretion, **may** grant the employee's request for Intermittent or Reduced Schedule Leave, or both.
- Employees on Intermittent or Reduced Schedule Leave must make certain elections in advance of the first day of such leave regarding the use of accrued leave balances and how the absence will be administered.

1. Intermittent Leave / Reduced Schedule Information
I must be absent on an intermittent or reduced schedule basis because **I** or **my FAMILY MEMBER (circle one)** requires medical treatment. To the best of my knowledge, the following information about the expected treatments is true.

Reason for leave: _____

Number of treatments: _____

Frequency of treatments: _____

Dates of treatments: _____

Length of post-treatment incapacitation: _____

2. Upon approval, you must provide your manager with your new schedule, including the approximate frequency, dates, and times of leave.

3. Intermittent Leave / Reduced Schedule Elections. Please check one of the following:

☐ I elect to use accrued leave balances to cover all intermittent or reduced schedule absences. I presently have sufficient balances so that, along with accruals gained during the period of absence, I will not be off payroll. I understand that by avoiding unpaid absences, there will be no effect on my right to accrue leave or insurance benefits.

☐ I elect to use accrued leave balances, but I will not have enough to cover all expected periods of absence. I elect to be off payroll for any absences not covered by accrued leave. I understand that I will not accrue leave for any pay period during which I am off payroll 25% or more of my scheduled hours.

☐ I elect not to use accrued leave balances. I understand that I will not accrue leave for any pay period during which I am off payroll, 20 hours or more.

4. I am aware that I must furnish medical certification of any serious health condition that is the basis for my leave request, and that I may be required to provide re-certification as reasonably requested by my employer.

☐ Certification of Health Care Provider form (Attachment B) is enclosed with this request.

NOTE: All hours, paid or unpaid, that are not worked and differ from your previous work schedule will count towards your leave entitlement.

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SECTION 4 – AGREEMENT and APPROVAL

I have read and fully understand the information documented here, as well as that contained in the PMLA Policy, #00001.

Employee Signature | Date

To be completed by the employee's supervisor:

Leave request is: ☐ Approved ☐ Not approved

If not approved, provide an explanation:

Supervisor Signature | Date

To be completed by HR:

Leave request is: Approved Not approved

If not approved, provide an explanation:

HR Signature | Date

Employee's last day worked:

Employee's return-to-work date:

Is this employee enrolled in VT State benefits? ☐ Yes ☐ No

☐ Health
☐ Dental
☐ FSA
☐ Voluntary Retirement
☐ Disability

File original in the employee's leave records and provide a copy to the employee and the employee's supervisor.