PTO Leave of Absence Request Form

Employee Information | **HR Approved** |

Last Name	First Name	J#	Home Phone #

Mailing Address	City	State	Zip Code	Work Phone #

Email Address	Supervisor's Name	Department's Title

Leave Information Select One: ☐ UH ☐ CWH ☐ Providence ☐ Other

Leave Start Date ____/____/____ Leave End Date ____/____/____

Apply for FML

(Read page 2 for additional information)

Select One
☐ New Leave
☐ Continuation of Leave

Select one: Intermittent FML?
☐ Yes ☐ No

Select Type of Leave

☐	**FML Employee's Illness** (Must use 40 hours of PTO at the beginning of leave, followed by EEI, if applicable until exhausted, thereafter PTO is optional.)
☐	**FML – Maternity** (Must use 40 hours of PTO at the beginning of leave, followed by up to five (5) weeks of EEI, if applicable, thereafter PTO is optional.)
☐	**FML – Bonding with a newborn child/Adoption/Foster Care Placement** (Use of PTO is optional)
☐	**FML – Family Member** (Use of PTO is mandatory) Check applicable box below: ☐ Spouse ☐ Child/Age _____ ☐ Parent
☐	**FML – Family Member who is a military service member on active duty or notified of an impending call or order to active duty** (Use of PTO is mandatory)
☐	**FML- Family Member who is a military service member with a serious injury or illness.** (Use of PTO is mandatory)

Apply for other leave of absence

☐	**Personal leave** (Paid or unpaid) Employee statement providing reason for request is required, and should be attached.
☐	**Military Leave** (Paid up to 168 hours per calendar year) Please provide copy of military orders.

Apply for On-The-Job (OJI) Wage Replacement Benefits

I understand that beginning with the fifth calendar day following the day of the incident the On-The-Job Injury Program will pay 66 2/3% of my regular rate of pay for time/wages lost as a result of an on-the-job injury and that this benefit is subject to all normal deductions (such as federal and state tax). I can supplement this reduced rate of pay with my accrued PTO hours.

If lost time resulting from an on-the-job injury exceeds two calendar weeks, the employee must apply for a leave of absence (FML, if eligible or Personal Leave) retroactive to the date of the injury. A new form must be submitted. A leave of absence and on-the-job injury leave will run concurrently and will not "stack" one after the other.

☐ **I do want to use my PTO to supplement my OJI wage replacement benefit.** (PTO hours used to supplement an OJI wage replacement benefit will not be reinstated.)

☐ **I do not want to use my PTO to supplement my OJI wage replacement benefit.**

Paid Time Off (PTO): (Once required PTO and EEI paid time have been used) Must select one:

☐ PTO: use all available

☐ PTO: use as follows

Effective Date: _____ End date: _____

☐ Without Pay

Employee Signature: _____ Date: _____

Acknowledgment of request: Supervisors, with regards to the personal leave of absence, your signature is your approval.

Department Supervisor: _____ Date:_____

Supervisor's phone number: _____ Supervisor's email:_____

This form must be filled out completely, including the supervisor's signature, and returned to the Human Resources Office by fax at 251-460-7483 or via email at leaveofabsencerequests@health.southalabama.edu.

USA HEALTH

PTO Leave of Absence Request Form

Additional Information:

1. This form is for **USA Health employees only**.
2. For information and eligibility regarding Short Term Disability (STD), please email leaveofabsencerequests@health.southalabama.edu.
3. **STD Benefits:** USA Health provides STD benefits at no cost to eligible employees upon completion of six months of employment. Eligible employees are regular USA Health employees appointed to a FTE of .50 or greater, working 20 hours or more per week. After a 15-day waiting period, benefits are paid at 60% of the employee's total weekly earnings, up to $1,000 per week for a covered disability. Benefits are payable up to 12 weeks, as long as the employee remains unable to work due to a covered disability.
4. Employees may not use accrued PTO while collecting STD pay. The STD benefit is a direct payment from the insurance carrier, The Standard, to the employee. Since the payment is not issued by the University's payroll office, and you are in an unpaid status, you must make direct payments to maintain your employee benefits active. Failure to maintain current premium payments will result in cancellation of coverage. Premium payments are due no later than the 25th of the month to maintain the next month's coverage. To make a payment please type **southalabama.edu/paynow** on your browser.
5. If you are a Health Care Authority (HCA) physician please contact the USA Health HR office for information regarding your Short Term Disability (STD) plan, via email at leaveofabsencerequests@health.southalabama.edu or phone call at (251) 460-6729.
6. How to complete this form:
    a. Under Leave Information, answer all questions. Leave start date and end date are required.
    b. You must make an election for all pay applicable statements.
    c. Sign and Date your form. Electronic signatures are accepted.
    d. Forward the completed form to your supervisor. Supervisor's signature is required under Acknowledgment of Request. Supervisors, with regards to the personal leave of absence, your signature is your approval. Electronic Signatures are accepted.
    e. The completed form, with the supervisor's signature, must be emailed to leaveofabsencerequests@health.southalabama.edu.
    f. The Human Resources office will communicate with you via regular mail and/or email regarding the required supporting documentation. Any documentation can be emailed back to Human Resources. *Please make sure your home address is correct. You may also list your personal email on the form for communication purposes.*

For additional information please visit:

https://www.southalabama.edu/departments/financialaffairs/hr/leavepolicies.html

For additional questions and guidance contact:
Phnita Jackson
Leave Specialist
(251) 460-6729