Form A

REQUEST YOUR LEAVE OF ABSENCE IN WORKDAY 30 DAYS PRIOR TO LEAVE OR AS SOON AS POSSIBLE

Leave of Absence Application-OhioHealth

Associate Health Phone: (614) 566-4100 or (740) 615-4100
Associate Health Fax: (614) 533-0039

COMPLETE AND SUBMIT TO ASSOCIATE HEALTH WITH REQUIRED FORMS FOR LEAVE OF ABSENCE PROCESSING

Associate Name:	Clock No.:	Department:
Address:		City, State, Zip:
Home/Cell/Work Phone Numbers:		E-mail Address:
Department Name:	Supervisor Manager Name:	Supervisor Manager Phone Number:

Type of Pay Requested:
□ TDP (70% temporary disability pay at my hourly rate of pay)
□ TDP with TAP supplemented for 100% of my regular pay
[NOT APPLICABLE FOR INTERMITTENT FMLA REQUESTS]
□ I have SSP

Personal Leave (is no longer handled by Associate Health)
Submit request to your **Manager through Workday** for processing
[For PL do NOT Submit this Form (A) to Associate Health]

OhioHealth O'Bleness Hospital Associates		
B.U. Associates		
Paid Time Choice	No. of Hours to Retain*	Order to Use (1,2,3)
Personal	(8)	
Vacation	(16)	
Personal Holiday	(16)	
* Maximum hours allowed to retain in parenthesis		

Reason for Leave of Absence (check all that apply):
□ My Own Serious Health Condition for Injury or Illness. Is condition work related? □ Yes □ No (If Yes, submit workers' compensation forms.)
□ My Child/Parent/Spouse's Serious Health Condition. If child, provide DOB: ___ / ___ / ___
□ Parental leave for: □ Maternity □ Parental □ Foster Care or Adoption
If pregnant or requesting parental leave, provide estimated due date: ___ / ___ / ___
Do you have a spouse that works for OhioHealth? □ Yes □ No

□ **Military Leave:** You or your manager are to request Military Leave in Workday. Submit official orders/schedule of annual training dates to include Military Unit Training Assemblies "MUTA" to Associate Health. Submit documentation of military pay and benefits during the period of leave to Payroll for processing upon your return.

□ **Qualifying Exigency Military FMLA** □ **Military Caregiver FMLA Leave [See Esource>Leave of Absence Forms]**

Types of Leave Needed (Check and complete dates for all that Apply)
□ **Continuous** (unable to work > 3 days) Begin Date: _____/_____/_____ Return to Work Date: _____/_____/_____
- Please have Physician complete **Form B** for symptoms/diagnosis or any regimen of continuing treatment

□ **Intermittent** (able to work, but may need time off periodically □ Initial Request □ Annual Renewal **[Submit Form C**]
□ **Restricted Duty and/or Hours** due to a temporary need **[Submit Form B]**

Conditions of Leave: I agree and accept the conditions of my leave of absence as follows:
- I understand that if I do not return when my leave expires, I will be considered to have voluntarily terminated my employment except if I am on Military Leave, I must return to work in compliance with USERRA.
- I understand if I accept other employment on leave, this will be considered voluntary resignation. I understand that my leave of absence is contingent upon my being a current associate.
- I understand my leave of absence is administrated by Associate Health and subject to OhioHealth Human Resources Policies.
- I will keep my manager and Associate Health updated during my leave of absence.
- I certify the above information is true and correct to the best of my knowledge and that intentional misrepresentation may result in termination.

Associate Signature: ____ **Date:** _____/_____/______