

Premera Return from Leave of Absence Form

This form must be received **at least three (3) business days prior to your return from leave**. Have it completed and signed by your Manager or Team Lead and fax to FMLASource at (877) 309-0218 who will then notify HR/Benefits of your planned return.

Associate name:	Associate number:
Supervisor/Team Lead:	Today's date:

Returning from Leave

I expect to return on this date: _____

My schedule upon return will be:

Full-time

Intermittent Schedule

Reduced Schedule: _____ hours per day _____ days per week

Required Certification

For leaves due to your own personal illness, you must provide a physician's release to return to work three (3) business days before return indicating you are able to return to work to perform essential job functions in order to be reinstated. You will not be reinstated until we receive the physician's release.

Terminating Employment

I do not intend to return to work.

I understand that this notification will result in the termination of my reinstatement rights, ineligibility for continued leave and discontinuance of employer-provided health care benefits, although, I will have an opportunity to continue health care benefits by enrolling in COBRA.

Required Signatures

(Supervisor/TL signature approval only needed for reduced or intermittent schedule)

Associate signature: X	Today's date:
Supervisor/Team Lead signature: X	Today's date: