SISTERS OF PROVIDENCE
HEALTH SYSTEM

Human Resources
Mercy Medical Center Campus
271 Carew Street • P.O. Box 9012
Springfield, MA 01102-9012
(413) 748-9601

REQUEST FOR LEAVE OF ABSENCE (LOA) FORM

Facility: ❑ Brightside for Families and Children ❑ Mercy Medical Center ❑ Mercy Home Care ❑ MIMA
❑ Providence Behavioral Health Hospital ❑ Health System Office ❑ Life Laboratories
❑ Mercy Senior Care Network *(facility)*:_____

Employee's Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Tel.:_____ Department Tel.:_____

Please complete the applicable section below and forward this form to your supervisor. You may apply for a leave of absence (unpaid, paid or combination thereof) under the SPHS Leave of Absence policy for one of the following:

Reason for Leave *(please check one)*:

❑ Non-FMLA Leave (does not qualify for Family and Medical Leave) *(up to 12 weeks)*
❑ Personal *(up to 30 calendar days)*
❑ Educational *(up to 12 months)*
❑ Administrative *(as determined)*

Anticipated Date of Leave:_____ Anticipated Date of Return:_____

I wish to use the following paid time off during the leave:

❑ CTO* ❑ EIT* ❑ ET ❑ Vacation ❑ Sick

* Your first scheduled work week must be paid from your CTO bank, and effective with your following scheduled work week, you are eligible to use your accrued EIT hours until your physician clears you to return to work or your hours are depleted.
Note: EIT/sick time may only be used for an **employee's own serious illness**.

During a paid leave, employee/employer contributions for benefit coverage will continue as well as accruals for paid time off. In the event that your leave becomes unpaid, you may continue benefits coverage by paying the employee's portion of contributions for the duration of the unpaid leave. Accruals for paid time off and contributions to the Pension Plan will cease during an unpaid leave. However, the time during which an employee is on leave will be included as continuous employment for purposes of computing length of service.

I understand that at the conclusion of approved leave, I will return to the same or similar position. I understand that failure to return to work on or before the scheduled return date indicated below shall be considered a voluntary resignation from Sisters of Providence Health System (SPHS), unless SPHS officially extends the leave.

I agree to provide a medical certificate from a physician verifying the serious health condition of myself, my spouse, child, or parent, if required. I hereby authorize SPHS to contact my physician to verify the reason for my requested leave or for any other related information concerning my leave, if required.

I have read and understand the attached LOA policy.

Employee's Signature:_____ Date:_____

Supervisor/Manager's Signature:_____ ❑ Aproved ❑ Denied** Date:_____

**Reason for denial:_____

For Human Resources Department Use Only

Human Resources Final Approval:_____ Date:_____

LOA Effective Date:_____ Return to Work Date:_____