BURGER
REHABILITATION SYSTEMS, INC.

LEAVE OF ABSENCE FORM

Instructions: Please read the applicable Leave of Absence Policy before completing this form. If you are eligible for a leave of absence, complete this form and submit to your supervisor.

Complete and fax back with Physician's document to HR at 916-983-5932

I. To be completed by Employee and Supervisor. (Please print.)

Name: _____Date of hire:_____ Location_____

_____Full Time _____ Part time (Hrs/Weeks _____)

On call employees must submit unavailability in writing.
Job Title: _____ Home Phone: _____

Home Address:_____City_____State_____Zip_____

II. Type of Leave Requested (Check all appropriate spaces.)
All medical leaves require health care provider documentation to indicate begin and approximate end date.
Note: Federal or State Family Care LOA (for employee's own disability) is counted concurrently with Medical LOA, unless the Medical LOA is for pregnancy disability, then State Family Care LOA may, if eligible, commence ***after*** pregnancy disability ends.
****Failure to submit required documentation may delay approval or commencement of leave.****
_____ General Medical (Integrate PTO with State Disability: _____Yes _____No
_____ Medical Maternity (Integrate PTO with State Disability: _____Yes _____No
_____ Medical Worker's Compensation (Integrate PTO with State Disability: _____Yes _____No
_____ Family Care* (Verification of circumstances may be required)
(Integrate PTO with Paid Family Care: _____Yes _____No)
_____Post Disability Maternity _____Spouse/Parent/Child
_____Paternity _____ Adoption/Foster Care

_____ Jury Duty
_____ Personal (unpaid time off for more than 14 calendar days)
_____ Military

III. Length of Leave: From:_____ Through:_____ Last day worked: _____

IV. I have read the Human Resources Policies and Procedures regarding Leaves of Absence and do hereby request a leave of absence as specified above.

Employee Signature: _____Date:_____

Supervisor Scheduling Needs: ___No coverage needed or (include dates and times if possible)
_____
_____

Supervisor Signature_____ Date: _____

Scheduling: Coverage Found: _____
Coverage Not Available _____
Scheduling Signature_____ Date: _____

Human Resources: ___ Approved ___ Denied ***Signature:*** _____ Date: _____CC:
Employee/Date _____

****All signatures need to be on form to be officially approved.****