Cura Home Health Inc.

License #374700050

REQUEST FOR TIME OFF

Information

Employee Name: _____

Beginning date of leave: _____

Expected date of return of leave: _____

Type of leave requested:

☐ **Sick** (AB 1522 Family Member Relationship: note specific dates of return)

☐ **Vacation** (Note specific dates of return to work)

☐ **Bereavement** (Family Members Relationship/ note specific date of return)

☐ **Time Off Without Pay** (Specific date of return)

☐ **Military Duty** (Copy of orders attached)

☐ **Jury Duty** (Attach copy of jury summons)

☐ **Maternity/Paternity** (Disability leave PDL, Attach Health Care Providers Certification)

☐ **Other**

You must submit requests for time off, other than sick leave, two days prior to the first day you will be absent. I understand and agree to comply with the following:

_____

Employee Signature *Date*

Manager Approval

- Employee must submit a health-care provider's verification of his/her fitness to return to work, including any limitations on the employee's ability to perform the essential duties of the job when returning from PDL, leaves.
- Employee agrees to provide updated health care provider certifications as requested by the Company.
- Employee agrees to follow all company policies relating to leaves of absence.
- Please note Personal time off/ leave without pay requests must be submitted in writing 30 days in advance. If the leave is for unforeseen or emergency reasons, an employee is required to give his or her Supervisor as much notice as possible if the30 day requirement cannot be met.
- Employees mush return to work on or before the agreed upon date. Failure of any employee to return to work on or before the agreed upon date, with a physician's release if required, will be interpreted as a voluntary resignation.

☐ Approved

☐ Any Documentation Attached Yes / No

_____

Manager Signature *Date*