

PTO Leave of Absence Request Form

Employee Information			•		HR Approved	
Last Name First Name			J#		Home Phone #	
Mailing Address		City	State	Zip Code	Work Phone #	
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Email Address			Supervisor's Name Department's Title			
<u>Leave Information</u>						
Leave Start Date			Leave End Date			
Apply for FML			Apply for On-The-Job (OJI) Wage			
(Read page 2 for additional information)			Replacement Benefits			
Select One Select one: Intermittent FML?			I understand that beginning with the fifth calendar day			
New Leave				following the day of the incident the On-The-Job Injury		
Continuation of Leave				Program will pay 66 2/3% of my regular rate of pay for		
Select Type of Leave			time/wages lost as a result of an on-the-job injury and that			
FML Employee's Illness (Must use 40 hours of			this benefit is subject to all normal deductions (such as			
PTO at the beginning of leave, followed by EEI, if			federal and state tax). I can supplement this reduced rate			
applicable until exhausted, thereafter PTO is			of pay with my accrued PTO hours.			
optional.) FML – Maternity (Must use 40 hours of PTO at the			If lost time resulting from an on-the-job injury exceeds two calendar weeks, the employee must apply for a leave of absence (FML, if eligible or Personal Leave) retroactive to the date of the injury. A new form must be submitted. A			
beginning of leave, followed by up to five (5) weeks of						
EEI, if applicable, thereafter PTO is optional.)						
FML – Bonding with a newborn						
child/Adoption/Foster Care Placement (Use of			leave of absence and on-the-job injury leave will run concurrently and will not "stack" one after the other.			
PTO is optional)			concurrently and win not stack one after the other.			
FML – Family Member (Use of PTO is mandatory)			☐ I do want to use my PTO to supplement my OJI wage replacement benefit. (PTO hours used to supplement an OJI wage replacement benefit will not be			
Check applicable box below:						
☐ Spouse ☐ Child/Age ☐ Parent						
FML – Family Member who is a military			einstated.)			
service member on active duty or notified of			□ I do not sweet to use my DTO to			
an impending call or order to active duty (Use			☐ I do not want to use my PTO to			
of PTO is mandatory)			supplement my OJI wage replacement benefit.			
☐ FML- Family Member who is a military service					nce required PTO and EEI	
member with a serious injury or illness. (Use of			paid time have been used) Must select one:			
PTO is mandatory)			☐ PTO: use all available			
Apply for other leave of absence						
Personal leave (Paid or unpaid) Employee			☐ PTO: use as follows			
statement providing reason for request is required, and should be attached.		Juirea,	Effective Date: End date:			
Military Leave (Paid up to 168 hours per calendar		alendar				
year) Please provide copy of military orders.			☐ Without	Pay		
Employee Signature:			Date:			
Employee Signature: Date: Acknowledgment of request: Supervisors, with regards to the personal leave of absence, your signature is your approval.						
Department Supervisor: Date:						
Supervisor's phone number:			Supervisor's email:			



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Additional Information:

- 1. This form is for **USA Health employees only**.
- 2. For information and eligibility regarding Short Term Disability (STD), please email leaveofabsencerequests@health.southalabama.edu.
- 3. **STD Benefits:**USA Health provides STD benefits at no cost to eligible employees upon completion of six months of employment. Eligible employees are regular USA Health employees appointed to a FTE of .50 or greater, working 20 hours or more per week. After a 15-day waiting period, benefits are paid at 60% of the employee's total weekly earnings, up to \$1,000 per week for a covered disability. Benefits are payable up to 12 weeks, as long as the employee remains unable to work due to a covered disability.
- 4. Employees may not use accrued PTO while collecting STD pay. The STD benefit is a direct payment from the insurance carrier, The Standard, to the employee. Since the payment is not issued by the University's payroll office, and you are in an unpaid status, you must make direct payments to maintain your employee benefits active. Failure to maintain current premium payments will result in cancellation of coverage. If you wish to pay online please contact the Payroll Office for instructions at 251-460-6471.
- 5. If you are a Health Care Authority (HCA) physician please contact the USA Health HR office for information regarding your Short Term Disability (STD) plan, via email at leaveofabsencerequests@health.southalabama.edu or phone call at (251) 410-5507.
- 6. How to complete this form:
 - a. Under Leave Information, answer all questions. Leave start date and end date are required.
 - b. You must make an election for all pay applicable statements.
 - c. Sign and Date your form. Electronic signatures are accepted.
 - d. Forward the completed form to your supervisor. Supervisor's signature is required under <u>Acknowledgment of Request</u>. Supervisors, with regards to the personal leave of absence, your signature is your approval. Electronic Signatures are accepted.
 - e. The completed form, with the supervisor's signature, must be emailed to leaveofabsencerequests@health.southalabama.edu.
 - f. The Human Resources office will communicate with you via regular mail and/or email regarding the required supporting documentation. Any documentation can be emailed back to Human Resources. Please make sure your home address is correct. You may also list your personal email on the form for communication purposes.

For additional information please visit:

https://www.southalabama.edu/departments/financialaffairs/hr/leavepolicies.html