LEAVE OF ABSENSE REQUEST FORM

Employee: Date Packet Provided to Employee:

Work Location: Supervisor:

Eligible employees are entitled Pacesetter Health's Parental Leave policy to 8 weeks of Unpaid Parental Leave in connection with the birth of an employee's child or the placement of an adopted child within an employee's home. This policy runs in tandem with any applicable laws.

Submit this request form to your supervisor at least 30 days before the leave is to commence. When submission of the request 30 days in advance is not possible, submit the request as early as is feasible. The employer reserves the right to deny or postpone leave for failure to give appropriate notice when such denial/postponement would be permitted under federal or state law.

ELIGIBILITY

To be eligible an employee must have worked for Pacesetter Health for at least 12 months and be classified as a Full Time employee working at least 30 hours per week.

REASONS FOR REQUESTING LEAVE:

Leave must be granted for any of the following reasons:

- For a serious health condition which makes you unable to perform your job;
- To care for your child, spouse, or parent who has a serious health condition; or
- To care for your child after birth, or for placement after adoption or foster care; or
- To address certain qualifying exigencies for military family on active duty or call to active duty status; or
- To care for a covered military service member.

I am requesting leave for the following reason:

☐ **Personal serious health condition**

☐ **Serious health condition of:**

☐ Spouse ☐ Child ☐ Parent

Name: _____

☐ **Birth of a child**

Expected delivery date is: _____

☐ **Adoption or placement of a child for foster care**

Child's name: _____

Scheduled date of adoption or placement: _____

☐ **Address certain qualifying exigencies for military family**

Period of covered military member's active duty: _____

PREMIUM PAYMENTS:

While you are on unpaid leave you will be expected to reimburse Pacesetter Health for any regular benefit payroll deductions that are missed. These payments are due monthly and will be withdrawn from your PTO or STD checks when possible. We will contact you for instructions on repayment if we are unable to take the payment from the PTO or STD check.

Medical: $_____.
Dental: $_____.
Vision: $_____.
STD: $_____.
CI: $_____.

DATES OF LEAVE REQUESTED:

I request leave from_____ to_____.

I request intermittent leave according to the following schedule: _____ I

request a reduced schedule leave according to the following schedule: _____

The total number of days of leave that I request is: _____

EMPLOYEE STATEMENT:

I agree to return to my original work schedule on_____. If circumstances change such that I will not be able to return to work on that date, I agree to inform my supervisor in writing immediately so that Pacesetter Health may start its search for a suitable replacement.

I understand that my benefits will continue during my leave and that I will arrange to pay my share of applicable premiums.

I understand that upon notification of intent not to return to work, my employment will be terminated, and I will be responsible to pay back any benefit premiums that Pacesetter Health has paid on my behalf.

Employee Signature: _____ Date: _____

TO BE COMPLETED BY HUMAN RESOURCES

Leave is: ☐ Approved ☐ Denied for the following reasons: _____

Request approved /denied by:_____

Corporate Signature: _____ Date: _____

Reporting While on Leave

If leave is taken because of an employee's own serious health condition or to care for a family member, employees must report periodically on their status and intent to return to work. In addition, employees must give notice as soon as practicable (within two business days if feasible) if the dates of leave change, are extended, or initially were unknown.

Health Benefits

Coverage under any Pacesetter Health provided group health plan will be maintained during any leave to the extent coverage would be maintained if you had been actively at work during the leave period. You are responsible for arranging with Human Resources the payment of the employee portion of any premiums. Failure to pay the employee portion of the premiums within 30 days of the due date will result in cancellation of your enrollment in that plan.

If an employee elects not to return to work for at least four consecutive workweeks at the end of the leave period, he/she will be required to reimburse Pacesetter Health for the cost of the health benefit premiums paid by Pacesetter Health for maintaining coverage during the leave. Pacesetter Health may recover its share of health plan premiums by taking deductions, to the extent permitted by law, from any unpaid wages, PTO pay, or other pay due you, or by initiating legal action. However, you will not be liable for the premiums if your failure to return to work is due to continuation of your own serious health condition or other reasons beyond your control.

Reinstatement

On return from an approved leave most employees will be returned to their same position held when leave commenced, or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment. In addition, if health care coverage lapsed because of lack of premium payment, upon return, health care coverage will be restored without preexisting condition, waiting period or medical examination.

Use of an approved family and medical leave will not result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Returning From Leave

If leave is taken because of an employee's own serious health condition (except when employee is taking intermittent leave), employees are required to provide medical certification that they are fit to resume work. Employees failing to provide the release from their healthcare provider will not be permitted to resume work until it is provided and may no longer be entitled to reinstatement.

LEAVE CERTIFICATION

Employee: Employer: Pacesetter Health

Patient (if other than employee): Relation to employee:

Begin date of requested leave: End date of requested leave:

Human Resources Contact: Jessica Neill Telephone: 314-451-4259

If leave is for my own health condition, I authorize my health care provider to provide my diagnosis.

Employee Signature: _____ Date: _____

HEALTH CARE PROVIDER AREA - EMPLOYEE'S SERIOUS HEALTH CONDITION

Does this employee have a serious health condition? (See previous page for definition)_____Yes _____No
If authorized, what is employee's diagnosis?

When did the serious health condition begin?

Please review the attached job description. Is this employee able to perform the functions of his or her job?
_____Yes _____No

If intermittent leave or a reduced work schedule is being considered, is it medically necessary?
_____Yes _____No If "yes", please describe the recommended schedule.

What is the anticipated return to work date?

IF LEAVE IS BECAUSE OF A SERIOUS HEALTH CONDITION OF FAMILY MEMBER

Does employee's family member have a serious health condition? _____Yes _____No
(See previous page for definition)

When did the serious health condition begin?

Is the employee's presence necessary or would it be beneficial to the patient? _____Yes _____No
(This may include psychological comfort and/or arranging for third-party care for the family member.)

If intermittent leave or a reduced work schedule is being considered, is it medically necessary?
_____Yes _____No If "yes", please describe the recommended schedule.

What is the anticipated return to work date?

Name of Health Care Provider: Specialty:

Address of Health Care Provider:

Signature of Health Care Provider_____ Date _____

RETURN TO WORK CERTIFICATION

Employee: Company: Pacesetter Health

Position:

Human Resources Contact: Jessica Neill Phone: 314-451-4259

Health Care Provider Section

Please complete the following and return prior to the return to work date.
Please review the attached job description. Is the employee able to perform all the functions of his or her job?
_____Yes _____No _____ Yes, with restrictions or accommodations.

Please list any restrictions or describe accommodations which the company should consider:

Are the restrictions: _____Permanent _____Temporary, until (date): _____

Additional Comments:

Employee is released to return to work effective (date):

Name of Health Care Provider: Specialty:

Address:

Signature of Health Care Provider _____Date_____

RECORD OF REDUCED WORK/INTERMITTENT LEAVE SCHEDULE FOR EXEMPT EMPLOYEES

(Executive, Administrative, and Professional Employees)

_____'s schedule during the period _____ to _____ will be as follows:_____

_____

_____ understands that if it becomes necessary to request a further schedule change because of the nature of the serious health condition necessitating the need for family and medical leave, he/she will give Pacesetter Health as much notice as possible and support the requested change with medical certification, if requested by his/her supervisor.

Employee: Position:

Manager:

Employee Signature: _____ Date: _____

Manager Signature: _____ Date: _____