LEAVE OF ABSENCE APPLICATION FORM

Leave Type: ☐ FMLA ☐ Personal Leave ☐ Adoption ☐ Military ☐ Paid Parental Leave

Section A: LOA APPLICATION – ASSOCIATES SECTION
TO BE COMPLETED BY ASSOCIATES FOR ALL LEAVE REASONS (Please print or type)

Associate Name:	Associate ID:
Associate Phone Number: Home: ( ) / Best # to call? / next number to call? Work: ( ) Ext.	Personal Email Address While On Leave:

Patient's Relationship to Employee (FMLA Requests Only):

☐ Self ☐ Spouse ☐ Parent ☐ Child – Child's Birth Date: _____/_____/_____

☐ Other (specify relationship): _____

Have you previously worked for ADP as a contingent worker (e.g., as a consultant or through an agency)? ☐ Yes ☐ No

If so, please provide the dates of service: _____

Associate's Current Home Street Address:	City:	State	Zip

Leave Request (e.g. 01/31/2021) From / / To / /	Last Day Worked / /	Intermittent Leave? ☐ Yes ☐ No

If the leave is for child care of an adopted child – please complete:

Estimated date of adoption: / /

Are you the primary care giver? ☐ Yes ☐ No Does the child's other parent work for ADP? ☐ Yes ☐ No

If the other parent works for ADP and will be taking an adoption leave, enter the other parent's name:

If you are requesting a Personal Leave - please have your HRBP or manager provide:

Accrual Balance for: Float Time: _____ Vacation Time: _____

Workplace Injury:

Please note: If you have been injured on the job and would like to initiate a Workers Compensation claim, you must immediately contact the HRPRC at 1-877-237-4711 and complete a separate form called the 'First Report of Injury'.

For all leave requests, please check or initial the following:

- ☐ I have received and read the Family and Medical Leave Act Notice included in the packet of information.
- ☐ I have read the Leave of Absence Benefit package specific to my leave.
- ☐ I understand a Medical Release to Return to Work Form that, if applicable, includes job restrictions / requests for accommodations must be completed and submitted to the ADP Leave Administrator prior to my return to active work.
- ☐ I authorize payroll deductions from my pay and, if necessary, agree to execute a repayment agreement as such time, for any overpayment
- ☐ I received while out on leave.
- ☐ I understand I have 30 days to submit FMLA forms for review.
- ☐ I understand failure to return to work or to keep my manager informed of my return to work may constitute job abandonment and lead to termination of my employment with ADP.
- ☐ I understand that my failure to complete any of the required forms within the specified time frames above may result in the discontinuation of my pay and may impact my continued employment.
- ☐ I understand that, if granted a leave, I may not seek or engage in gainful employment elsewhere (unless I have been called to active duty service if the U.S. Military.

(For FMLA ONLY) I hereby authorize my health care provider to complete a Certification of Health Care Provider (Family and Medical Leave Act 1993) and submit the certification to the ADP Leave Administrator in order to determine whether my absences are qualified under FMLA of 1993. I further authorize my health care provider to clarify and / or authenticate the Certification if contacted by Health Care Provider acting under the supervision of a health care provider representing ADP.

ASSOCIATE'S SIGNATURE (Must Sign to Proceed with Leave Request)	**DATE** (e.g. 7/1/2022)