LEAVE OF ABSENCE APPLICATION FORM

Leave Type: ☐ **FMLA (Federal and/or State)** ☐ **Short-term Disability**
☐ **Personal Leave** ☐ **Military Leave**

Section A - TO BE COMPLETED BY EMPLOYEE				
Employee Name (First, MI, Last)		Employee ID:		
Employee Phone Number Home: ( )		Work: ( )		
Patient's Relationship To Employee (FMLA and State Leave Requests Only) ☐ Self ☐ Spouse ☐ Parent ☐ Child - *Child's Birth Date:* ________________ ☐ Domestic or Civil Union Partner ☐Other:				
Employee's Home Street Address	City		State	Zip
Leave Request: (e.g. 01/31/2003) From / / to / /	Last Day Worked: / /	Intermittent Leave ☐ No ☐ Yes		
Reason for Employee Leave: (If leave is for a family member, explain the care you will provide. If "in loco parentis" status applies, please explain your relationship to the person needing care. "In loco parentis" refers to someone with day-to-day responsibilities to care for and financially support a child, or a person who had such responsibility for the employee when the employee was a child.)				

Please read the following statements. Your signature below will serve as confirmation that you have read and understand these guidelines.

- I have received and read the Family and Medical Leave Act Notice included in this packet of information.
- I have read my employer's policies specific to leaves of absence.
- I understand I have 15 days to submit FMLA forms for review. In case of a Short-term Disability denial, I have 15 days to submit FMLA forms from the date on the written denial from the STD vendor.
- I understand my failure to complete any of the required forms within the specified timeframes above may result in the denial of my leave and discontinuation of pay.
- I understand a Medical Release to Return to Work form, if applicable, that includes job restrictions and requests for accommodations must be completed and submitted to my Supervisor/Manager prior to my return to active work.
- I understand failure to return to work or to keep my employer and Sunrise Senior Living Leaves Administration informed of my return to work may constitute job abandonment and lead to termination of my employment with Sunrise Senior Living.
- I hereby authorize my employer's designee to contact me or my family member's treating health care provider to clarify or authenticate the medical certification if applicable.

EMPLOYEE'S SIGNATURE (Must Sign to Proceed with Leave Request)	**DATE (e.g. MM/DD/YYYY)**

Return to:
Sunrise Senior Living Leaves Administration
P.O. Box 1806
Alpharetta, GA 30023-1806
Phone: 1-888-779-8672
Fax: 1-866-568-6444