TG TAM Leave Administration
LEAVE OF ABSENCE APPLICATION FORM

Please mail, fax or upload a copy of the completed and signed application form.

TG TAM Leave Administration, PO Box 1806, Alpharetta, GA 30023-1806
Phone: 1-800-809-5462 Fax: 1-866-568-6444

Section A - TO BE COMPLETED BY EMPLOYEE

Employee Name (First, MI, Last) Employee ID / File#:

Employee Phone Number Home: ( ) Cell: ( )

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. mm/dd/yyyy) From / / to / /	Last Day Worked: / /	Intermittent Leave ☐ No ☐ Yes
Manager and Supervisor Names:	Department Name:	Hourly or Salary ☐ Hourly ☐ Salary

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.)

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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, including personal leaves. For TG policies, please contact your local HR Representative.
- I understand I have 20 days to submit Certification of Healthcare Provider for Employee or Family Member Serious Health Condition forms for review.
- In case of a Short-term Disability denial, I have 20 days to submit Certification of Healthcare Provider for Employee or Family Member Serious Health Condition 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.
- I understand a Return to Work Certification form, if applicable, that includes job restrictions and requests for accommodations must be completed and submitted to your Human Resources Department prior to my return to active work.
- I understand failure to return to work or to keep my employer and TG TAM Leave Administration informed of my return to work may constitute job abandonment and lead to termination of my employment with Toyoda Gosei.
- I hereby authorize my employer's designee to contact my, or my family member's, treating health care provider to clarify or authenticate the medical certification if applicable.

EMPLOYEES SIGNATURE (Must Sign to Proceed with Leave Request)	**DATE (e.g. mm/dd/yyyy)**
HUMAN RESOURCES SIGNATURE (Required for State Mandated Pregnancy Accommodation Leaves)	**DATE (e.g. mm/dd/yyyy)**