S^D Associates LLC

Behavioral Services **Assessment, Consultation, Training and Direct Service**

37 Talcott Road, Suite 114, Williston, VT 05495 ***www.sdplus.org*** **(802) 662-7832**

Unpaid Leave of Absence Request Form

An unpaid leave of absence is available in certain circumstances as described in S^D Associates' Employee Policy Manual. Employees who meet the eligibility criteria for a leave of absence must complete this form at least 30 days prior to the commencement of leave or as soon as practicable in the event of an unforeseeable absence.

Please note:

- All leaves of absence must be approved in advance by program director and human resources.
- If the dates of requested leave change, a new leave of absence request form must be submitted for approval.
- Employees on an unpaid leave of absence are responsible for payment of insurance premiums as agreed upon with HR prior to the commencement of leave.
- Employees returning from a leave of absence must contact HR at least one week in advance of the projected return date.

See SD Associates LLC Employee Policy Manual, Section V. Employee Time Off, Leave of Absence for the full details on unpaid leaves of absence, including eligibility.

This form should not be used to request leave under the Family and Medical Leave Act (FMLA) or to request leave as an accommodation under the Americans with Disabilities Act (ADA). Employees should consult with HR to request leave under the FMLA or ADA.

To be completed by the employee:

Date of request: _____ Employee name: _____

Work Location: _____ Job title: _____

Date of hire: _____

Employee status: ( ) Exempt ( ) Nonexempt ( ) Full time ( ) Part time

Requested leave dates (mm/dd/yy): _____ to _____.

Reason for the leave of absence:

_____

_____

I have read and fully understand the information contained in S^D Associates' leave of absence policy.

_____ _____

Employee signature Date

3.26.2021

To be completed by the program director:

Leave request is:

____ Approved for the following time period:_____

The following benefits will still be available during your leave:

___ PTO accrual ____ Tuition accrual _____ Company contribution to Medical

___ Other _____

Will accrued PTO need to be used during this leave _____yes or no_____

Additional details:

_____

_____

_____

_____

_____

____ Not approved

Explanation:

_____

_____

_____

_____

_____

Director signature: _____ Date: _____

To be completed by HR:

Employee's last day worked: _____ Employee's return-to-work date: _____

Insurance to be continued and the weekly/monthly cost to employee:

Medical	( ) Yes	( ) No	( ) N/A	$_____
Dental	( ) Yes	( ) No	( ) N/A	$_____
Vision	( ) Yes	( ) No	( ) N/A	$_____

Total insurance premium due per week: $_____

Total insurance premium due per month: $_____

HR signature: _____ Date: _____

File original in the employee's leave records and provide a copy to the employee.