Diocese of Rockford
Health Insurance Trust
555 Colman Center Drive
P.O. Box 7044
Rockford IL 61125

815/399-4300
FAX 815/997-5225

REQUEST FOR FAMILY/MEDICAL LEAVE OF ABSENCE

Employee_____

Employer_____

Supervisor's Signature_____

Last Day of Work_____ Will Return to Work On_____

Reason for Request of Leave_____

_____

I understand that if reason for request is for a serious health condition, I must promptly submit medical verification.

I understand that failure to return to work at the expiration of the leave of absence, or failure to secure an approved extension prior to the expiration of the leave of absence, will be considered a voluntary resignation of my position. I further understand that my employer will use its best efforts to return me to the position I held prior to the approved leave of absence, but if it is not available, will place me in a substantially equivalent position.

I further understand and agree that if my leave of absence request is approved, and I elect not to return to work at the expiration of my approved leave of absence, my employer shall be entitled to recover from me personally the cost of premiums paid to maintain my (and my dependent(s)', if applicable) group health plan coverage during the period of leave of absence.

_____ _____

Employee Date