

REQUEST FOR MEDICAL LEAVE WITHOUT PAY FORM

Employee's Name (Print)

Social Security #

Department

1. Reason for Medical Leave Without Pay:

____ Employee's serious health condition

____ To care for a family member's serious health condition

____ Birth or adoption of a child

If leave is to care for a family member, list the family member's name and relation below:

Name of Family Member

Relationship to Employee

2. I request Medical Leave Without Pay beginning on _____
and ending _____

(date)

(date)

3. Maintenance of Benefits

I agree to pay the employee portion of my current benefits directly to The Citadel in order to have my coverage maintained while I am on Medical Leave Without Pay status. Benefits must be paid by the 20th of each month for the following month's coverage (For example, to maintain your benefits for the month of May, The Citadel must receive your payment by April 20th). Failure to pay benefits on time may result in termination of coverage.

_____ I understand the information regarding payment of premiums and wish to have The Citadel maintain all of my current coverages.

_____ I understand the information regarding payment of premiums and wish to have The Citadel maintain only the following coverages:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

___ I do not wish to have my coverages maintained while on Medical Leave of Absence. Coverage will terminate at the end of the month following my last day on pay status.

The total that I must pay to maintain my coverage is :

4. Medical Certification

Please provide medical certification from the treating physician and attach to this form. The Citadel does have the right to request a second opinion prior to approving the medical leave request. The Citadel also has the right to request recertification no more than every thirty (30) days while the employee is on medical leave without pay.

_____ I understand the information regarding medical certification as stated above and in The Citadel's Medical Leave Without Pay policy. I authorize my doctor to provide medical certification to The Citadel regarding my request for medical leave.

Employee's Signature

Date

For Use by Department Head or Supervisor

I approve the above request for Medical Leave of Absence without pay.

Department Head / Supervisor

Date

For Human Resources Use

The above request has been ___approved___ ___disapproved___

Medical Leave Without Pay will begin effective _____ and will end _____. Medical release by the physician or the death of the family member being cared for will result in termination of the Medical Leave Without Pay prior to fore mentioned end date.

Human Resources Director

Date