LEAVE OF ABSENCE REQUEST FORM

Section 1: To be completed by employee

Employee Name (First, Middle Initial, Last): ______________________

Position Title: ______________________

Practice/Location Name: ______________________

Practice/Location Address: ______________________

Reason for Requested Leave

Employee Medical ◯ Family Medical ◯ Military ◯

Leave Duration

Requested Start Date of Leave: ______________________

Anticipated Return to Work Date: ______________________

Type of Leave

Continuous ◯ Reduced Schedule* ◯ Intermittent* ◯ Other** ◯

*If intermittent or reduced, please give a schedule of your anticipated availability:

**If other, please specify: ______________________

Additional Reasons:

◯ Birth of a son or daughter of the employee and to care for such child Placement of a son or

◯ daughter of the employee and to care for such child

◯ Because of my serious health condition, which makes me unable to perform myposition’s essential functions

◯ To care for a spouse, parent, or child with a severe health condition

Employee Signature: ______________________ **Date:** ______________________

Section 2: To be completed by Supervisor/Manager

Supervisor/Manager Name: ______________________

*By signing this document, you acknowledge that you are responsible for your insurance premium during the duration of your leave. If you have any questions regarding your premium payment, please reach out to Human Resources.

Signature of Receipt: ______________________ Date: ______________________

Please return completed form to HR@SelectDentalManagement.com Rev 03/1/2022