REQUEST FOR SHORT TERM DISABILITY LEAVE AND/OR FAMILY MEDICAL LEAVE

Please complete this form and fax to (407) 650-2583 or email to amonday@smokeybones.com

Section A

Firestarter Name (Last, First, MI):	SSN: - -	Hire Date:	Home Phone: - -

Street Address:	City:	State:	Zip Code:

Location: ☐ Corporate ☐ Restaurant Number ____	Manager/Director's Name:

Reason for Leave ***(Select only one):***	***Request is for:***	***Dates of Requested Leave:***
☐ Medical (for self) ☐ Medical (care of family member) ☐ Birth/Adoption/Foster Care ☐ Non-Medical military qualifying events	☐ ***Continuous leave*** ☐ ***Intermittent leave***	**(Leave start date and anticipated return date required)** Beginning _____ Ending _____

Section B: Firestarter Statement of Intent and Understanding

PLEASE READ EACH STATEMENT BELOW AND INITIAL IN THE SPACE PROVIDED BEFORE RETURNING TO YOUR LEAVE ADMINISTRATOR.

1. _____ I understand that I must contact my Director/Manager when I am unable to be at work as scheduled, regardless of the length of time I expect to be absent. I will provide expected dates that I will be absent and an expected return to work date as soon as it is known. I understand that I am not obligated to share information with my manager about the nature of my injury or illness.

2. _____ I understand approval of this leave will be contingent upon timely submission of required documentation and/or certifications.

3. _____ I understand that in order to be eligible for leave under the Family Medical Leave Act (FMLA), I must have worked for Smokey Bones for a minimum of 12 months and at least 1250 hours in the immediate 12-month period preceding my leave or at a minimum, at least 12 months during the last 7 years. I further understand that under the FMLA, I have the right to be restored to my same position or an equivalent position upon my return from leave, subject to the rules of the FMLA.

4. _____ I understand that any time I spend on approved Short-Term Disability will run concurrently with any FMLA leave to which I may be entitled.

5. _____ I will notify my Director/Manager and Human Resources at least 3 working days prior to my return. I understand that if I don't provide prior notice of my return to work, I may be required to take a vacation or an unpaid day while my manager adjusts work assignments. I will also promptly notify Human Resources and my director/manager before my return date if I cannot, or choose not to, return to work, or if I request an extension of my leave. If I am out, I MUST also provide the appropriate certification for an extension before my return date.

6. _____ I understand that under the Short-Term Disability Program, my position may be released if I am unable to return from leave within 90 days of the first day of my leave.

7. _____ If I do not return to work on my scheduled return date, or if I fail to obtain an extension, I understand that Smokey Bones may consider my failure to return a voluntary resignation based on job abandonment.

8. _____ If requested, I agree to furnish Smokey Bones with appropriate certification and re-certification, as required, regarding my inability to work. I understand failure to do so could result in my request for leave being denied or delayed.

9. _____ If I am out on Short-Term Disability, I agree to furnish Human Resources with a release to return to work indicating my ability to return to work by the first day of my return. I understand failure to do so could result in my reinstatement of employment being delayed.

10. _____ If I am out on Short-Term Disability, I understand that no benefit is payable until my disability leave has been approved by CIGNA. Once approved, I will receive payment for the approved period on the next regular benefit cycle. Payment will be issued for future time approved on the pay period it would regularly be paid**.**

11. _____ By completing and submitting this form, I confirm that I have read and understand the information contained in this Request for Leave of Absence Form and the Employee Statement of Intent and Understanding regarding my leave of absence. I understand my rights and responsibilities during my leave, as well as the impact, if any, to my pay and benefits.

12. _____ I have read the Leave of Absence information provided by Smokey Bones and had the opportunity to ask any additional questions.

Firestarter signature: _____ Date: _____