## LEAVE REQUEST FORM

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## [Organization Name] has implemented this form to accommodate leave of absence requests in accordance with the employment standards regulations of the employee’s province/territory of residence. Please complete this form and submit it to [Insert Title] at least 4 weeks prior (where possible) to the intended start-date of the leave with the required information to facilitate the process.

EMPLOYEE INFORMATION

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Number #/Department/Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TYPE OF LEAVE (Check all that apply)

* Maternity/Pregnancy Leave
* Parental Leave
* Bereavement Leave
* Compassionate Care Leave
* Critical Illness Leave
* Organ Donor Leave
* Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note, this form may be utilized to apply for maternity leave and parental leave simultaneously.

LEAVE DETAILS

Expected Start Date of Leave: [Expected Start Date MM/DD/YYYY] (Last working day)

Expected Return to Work Date: [Expected Return Date MM/DD/YYYY]

Total Duration of Leave: [Total Duration in weeks]

In accordance with the employment standards regulations of the province of employment, [Organization Name] may request medical documentation or other documents supporting the leave.

ACKNOWLEDGEMENT AND AGREEMENT

By signing this request form, you acknowledge the following:

* You have provided accurate information regarding the expected start date and return date of your leave.
* You understand that you are required to provide the applicable amount of notice prior to starting the leave, in accordance with the Protected Leaves Policy.
* You understand that your job will be protected for employment standards leaves, and you will be reinstated to the same position or a comparable position upon your return.
* You understand that the company may require medical or other documentation to support your leave request, in accordance with the employment standards regulations of the province of employment.
* You understand that during specific leaves of absence, you are entitled to continue participating in any benefit plans you are currently enrolled in, provided that you continue to pay your portion of the premiums, if applicable (please speak with your supervisor for clarification on this).
* You can therefore (please select one):
	+ Remain on benefits and continue paying premiums per month (Insert person) will provide instructions on how to pay the premiums by e-transfers, void cheques, or payment in advance), OR
	+ Opt out of benefits for the duration of the leave and provide a written request to opt out of benefits

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_