



Employee Name: _____

Phone Number: _____

Location & Title: _____

Employee ID: _____

TYPE OF LEAVE ☐ **Paid (if balance available)** ☐ **Unpaid (if no balance available)**
☐ Medical/Disability - medical certification required☐ Military - military orders required☐ Personal / Educational / Sabbatical / Family Member☐ Delaware Paid Leave Program through the Department of Labor (DOL)☐ Extension of Leave - I am extending my original return to work through _____
☐ I am also applying for FMLA in order to maintain my current health insurance coverage for twelve weeks. I understand that I may only use 12 weeks of FMLA during any year and medical certification is required.

Anticipated Leave Date: _____ Anticipated Return to Work Date: _____

EMPLOYEE LEAVE ONLY FOR MEDICAL REASONS: By Delaware State Law, you are required to file a Short-Term Disability claim with The Hartford. The Hartford will pay 75% of your salary for contractual days and you may choose to supplement 1/4 day of sick leave to receive 100% of your salary (if you have leave available to use). ☐ ***Yes, supplement*** ☐ ***No, do not supplement***

Employee Signature_____
Date

****HR USE ONLY****
Type of Leave: _____ 1st day out: _____

Sick Leave Exhausted: _____ Supplement 25% leave with STD YES / NO

Contract Payoff: _____ AESOP/DSC updated: _____

FMLA/STD documents given to EE: _____ STD claim #: _____

STD Begin: _____ STD Max: _____ LTD packet sent: _____

Notes: _____

RTW: _____ Salary Re-calc: _____