Leave of Absence / Disability Coordination Agreement

Employee Name: _____
Manager Name: _____
Date: _____

Type of Leave (Please check appropriate reason)

Medical Leaves:

__ Medical Maternity
__ Industrial (Work Related)
__ Other Medical Disability (Non-Work Related)

Non-Medical Leaves:

__ Family
__ Jury Duty
__ Personal
__ Military

Please fill in your Last Day Worked, First Day of Leave and Expected Return to Work Date only. Base your First Day of Leave on a calendar day, not a work day.

Last Day Worked: _____

First Day of Leave: _____

Expected Return to Work Date: _____

Actual Return to Work Date: _____

Please coordinate my disability with my accrued sick / vacation hours: __ Yes __ No

Continued Benefits Coverage

Please check with your designated company representative to see if your benefits are automatically continued while going on a Leave status. If applicable, employees will be expected to make any applicable premium payment(s). This will be handled as usual through payroll deductions. If employees are not receiving a paycheck, they will need to make arrangements for premium payment while out on Leave (if applicable). Employees will stop accruing (sick / vacation) time if their Leave lasts longer than thirty (30) days.

If the Leave lasts longer than three (3) months, the employee may qualify to elect benefits continuation through COBRA if J P Systems, Inc. is legally obligated to provide COBRA coverage. The employee must notify her/his designated company representative at that point.

Agreement

My signature on this document signifies that I have received copies of all applicable forms and understand the effect of my Leave on my benefits. I understand that, if possible, I am expected to contact my designated company representative at least one (1) week prior to my expected return date to confirm my availability. If I do not contact my designated company representative on or before the above return date I am considered to have voluntarily resigned on the scheduled last day of the leave.

I understand that except for pregnancy disability leave, any medical/disability leave may automatically be applied towards that allowed by the Federal Family Medical Leave Act and any other state act, if applicable. A request for an extension of my Leave of Absence must be received prior to the expiration of the original LOA. Any extension must be approved by my designated company representative. An extension of a Medical LOA must be accompanied by a written statement by my attending physician.

I have read and understand the above information.

_____	_____
Employee Signature	Date
_____	_____
Manager Signature	Date