Imagine Early Learning Centers

EMPLOYEE LEAVE OF ABSENCE ACKNOWLEDGEMENT

This Acknowledgement must be completed in its entirety. **DO NOT** leave any section blank. Failure to do so may result in denial of your request for a leave of absence.

You MUST submit this Acknowledgement Form to your **Director AND Upload** it to your leave account.

Type(s) of Leave of Absence (LOA): _____

Dates for Requested Leave:

Last Day of Work Date: _____/_____/_____
Start Date of leave: _____/_____/_____
End Date of leave: _____/_____/_____
Expected Return to Work Date: _____/_____/_____
Total leave time (in weeks and/or days): _____

Request of Vacation and/or Sick Payment or Non-Payment During Your LOA:

Circle below if you would like to be paid out your total accrued balance for the following types of LOA:
FMLA, NYS DBL, NYS PFL, NJ FLA, NJ TDI, NJ FLI, WC

TOTAL VACATION HOURS	YES - PAY OUT	N0 - DO NOT PAY OUT
TOTAL SICK HOURS	YES - PAY OUT	NO - DO NOT PAY OUT

You can email status-change@imagineelc.com to change your above circled selection which will be processed in the next payroll cycle, after HR reviews your request.

Other LOA's require employees to use vacation and/or sick paid time off as per the respective Policies and are not at the employee's discretion. HR will pay out accordingly.

- I acknowledge and agree to return to work on _____. Should circumstances change, I agree to notify my employer, Imagine Early Learning Centers, in writing WITHIN TWO (2) weeks of my expected return to work date and prove that the responsibility of my job can be undertaken in the future.
- I acknowledge that I understand the contents of the Leave of Absence Request Policy and agree to abide by all requirements.
- I agree to provide my employer, Imagine Early Learning Centers, with any requested documentation and medical certification that is permitted under the clauses of federal, state and local laws, including the Medical Evaluation Certification Form. I understand that I must adhere to Imagine's Deduction Policy as stated in the Employee Handbook and continue to either pay my share of benefits or agree to the payment plan upon my return as per HR. I understand that the continuation of my health care benefits is contingent upon my continued payment for my regular health care deductions.
- I understand that my position becomes vacant if I do not return to work following the date my approved leave(s) end(s).
- I understand that I do not accrue vacation or sick time while I am on any approved leave.
- I agree to confirm to my Director my return to work date two (2) weeks prior to reporting to work.

_____ _____ _____
Print Name Signature Date