

Family Medical Leave Request

Employee Information

Employee Name (Last, First, M.I.) <small>PLEASE PRINT</small>	Employee No.	Employee Telephone Number
Employee Address	City	State Zip
Name of person who completed form (if not the Employee)		Employee's Supervisor's Name

Purpose of Leave

Type of leave requested: Check all that apply

Paid Vacation Unpaid Time Off

Purpose of leave: Check all that apply

1. The birth of a child, or the placement of a child with you for adoption or foster care.
2. Your own serious health condition.
3. Because you are needed to care for your spouse, child, or parent due to his/her serious health condition.
4. Because of a qualifying exigency arising out of the fact that your spouse, son or daughter, or parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
5. Because you are the spouse, son or daughter, parent, or next of kin of a covered servicemember with a serious injury or illness.

Provide a brief description:

Shift _____ If Part-time, provide hours worked _____

Does the employee request intermittent leave or a reduced work schedule? If intermittent leave is approved, employee must schedule appointments outside of scheduled work hours whenever possible.

No Yes - If yes, explain why intermittent leave or a reduced work schedule is necessary, and the schedule for treatment:

Have you worked for a temp agency or contractor of ACS, or for ABX Air?

Yes No If Yes, provide dates _____ Name of Company: _____

From To Address: _____

Phone: _____

Anticipated Starting Date	Anticipated Ending Date	Today's Date	Was the employer notified about the leave at an earlier date?
/ /	/ /	/ /	No Yes, give date of earlier notification / /

Has 30 days advance notice been given? To whom was it reported:

Yes No - Give Explanation for delay in providing notice to employer:

Intention to return to work at ACS (Check one box)

I will NOT be returning to work at ACS.

I may be unable to work at ACS at the end of my leave, but I desire to return to work at a later date if possible.

I intend to return to work at ACS when my leave ends.

DOH _____

Hrs. _____

P.U. _____

I certify that the above information is true and correct to the best of my knowledge. I understand that any intentional misrepresentation concerning the above facts can result in the termination of employment.

I have read and understand the Family Medical Leave Policy Outline (see reverse) and I agree to its terms and conditions.

X _____ Date _____

Signature of Person who completed this form

ACS Family Medical Leave Policy Outline

Family Medical Leave Act (FMLA) requires covered employers to provide up to twelve (12) weeks of unpaid, job protected leave during a rolling twelve (12) month period to “eligible” employees for certain family and medical reasons and up to twenty-six (26) weeks of leave in a single twelve (12) month period to “eligible” employees for a covered servicemember. Employees are eligible if they have been employed by ACS for at least one (1) year and have worked 1,250 hours over the previous twelve (12) months.

REASONS FOR TAKING LEAVE: Unpaid leave must be granted for any of the following reasons:

- The birth of a child, or placement of a child with you for adoption or foster care.
- Your own serious health condition.
- Because you are needed to care for your spouse, child, or parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your spouse, son or daughter, or parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the spouse, son or daughter, parent, or next of kin of a covered servicemember with a serious injury or illness.

At the employee or employer’s option, certain kinds of paid leave may be substituted for unpaid leave.

ADVANCE NOTICE AND CERTIFICATIONS: The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide thirty (30) days advance notice when the leave is “foreseeable”.
- Medical certification to support a request for leave because of a serious health condition is required within fifteen (15) calendar days of the Company’s request.
- Certification to support a request for leave because of a qualifying military exigency is required within fifteen (15) calendar days of the Company’s request.

JOB BENEFITS AND PROTECTION:

- For the duration of the FML, the employer must maintain the employee’s health coverage under any “group health plan”, provided employees pay their portion of the premium.
- You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse.
- Upon return from FML, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FML cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

FML APPROVAL:

- FML is conditionally approved for eligible employees pending receipt of medical certification in accordance with the federal FMLA regulations. Failure to provide medical certification will cause the leave request to be denied or delayed and ACS attendance policies will apply.

HOW TO REQUEST FML:

- FML is requested by completing the FML Request Form and submitting it to the address below.
 - If the leave is planned, thirty days notice should be given. If unforeseeable/unplanned (e.g., medical emergency), notice must be given as soon as possible.
- Forms are located at the Communications Centers, at www.myabx.com, or by contacting the HR Department.

INSURANCE PREMIUMS:

- Employees must pay their portion of any health or voluntary life insurance premiums.

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