995 Worthington Street, Springfield, MA 01109
Telephone (413) 734-5376 FAX (413) 737-7949

REQUEST FOR MEDICAL LEAVE ASSISTANCE FORM

Requesting Employee Name	Date
Address	Contact Phone Number(s):
Program/Department	Position

I hereby request to receive _____ hours of MPTO from the Medical Leave Assistance Bank. I have met the following criteria:

- ☐ **I have exhausted all my sick and PTO hours within the last two weeks or anticipate that I will exhaust all benefit time while on leave.**
- ☐ **I am not receiving short term disability, workers compensation or long term disability insurance benefits.**
- ☐ **I have a serious, non-work related illness or injury requiring inpatient care or continuing treatment of a health care provider and have submitted a completed Certification of Health Care Provider for Employee's Serious Health Condition to Human Resources.**
- ☐ **I am an employee in good standing.**

Furthermore I understand that I cannot request/receive more than two weeks of my regularly scheduled hours and that any unused donated hours will revert back to the Bank upon my return to work.

_____

Employee Signature or designee Date

SUBMIT COMPLETED FORM TO HUMAN RESOURCES

FOR HUMAN RESOURCES/PAYROLL USE ONLY:

Status of Employee: PTR # of hours _____ FT # of hours _____ Present Balances: PTO _____Sick_____

Estimated Date of Return to Work: _____

In accordance with the provisions of the Medical Leave Assistance Program this request is:

☐ **APPROVED** ☐ **DENIED** (Reason) _____

Total MPTO Hours Eligible: _____Check Dates/Hours Used: ___/____/____ ____/____/____ ____

HR to complete manual timesheet(s) for employee and give to Payroll for applicable weeks.

_____ _____

Human Resource Mgr. or Designee Date

Original: Employee File Copy: Employee