

REQUEST FOR FAMILY AND/OR ANY LEAVE
PLEASE PRINT

HERITAGE PRODUCTS, INC.
2000 Smith Avenue
Crawfordsville, IN 47933

Request for Family or any leave must be made, if practical, at least 30 days prior to the date the requested leave is to begin.

Name _____ Date ____/____/____

Department _____ Title _____

A. I request Family Leave for one or more of the following reasons:

____ Because of the birth of my child and in order to care for him or her.

Expected date of birth ____/____/____ Actual date of birth ____/____/____

Leave to start ____/____/____ Expected return date ____/____/____

____ Because of the placement of a child with me for adoption or foster care.

Date of placement _____ Leave to start _____ Expected return date _____

____ In order to care for my spouse, child or parent, who has a serious health condition.*

Leave to start ____/____/____ Expected return date ____/____/____

B. I request Medical leave which may qualify me for Short Term-Long Term Disability or Worker Compensation.

____ For a serious health condition that makes me unable to perform my job.*

Describe: _____

Leave to start ____/____/____ Expected return date ____/____/____

* A physician's certification may be required for leave due to a serious health condition.

____ For other reasons. Describe: _____

Leave to start ____/____/____ Expected return date ____/____/____

____ Requested intermittent leave schedule (if applicable; subject to employer's approval)

Have you taken a family or medical leave in the past 12 months? ____ Yes ____ No

If yes, how many workdays? _____

I understand and agree to the following provisions:

- * If I have worked for my employer at least one year and at least 1250 hours in the previous 12 months I will be qualified for job protection under the Family and Medical Leave Act for up to 12 weeks.
- * This leave will be unpaid, unless it is covered under the Heritage Products, Inc. Short Term-Long Term Disability plan, or under the Indiana Worker Compensation Act.
- * I will be required to exhaust my paid vacation as part of my 12 weeks, if this leave is requested for the care of a family member other than my own disability.
- * The first 12 weeks of my absence whether for care of a family member, or my own disability will be charged under the Family and Medical Leave Act.
- * After 12 weeks of leave, if I do not return to work, my current position may be filled by another Team Member.

Employee Signature _____ Date ____ / ____ / ____

Leave Approval

For full day leave:

Manager/Supervisor Signature _____ Date ____ / ____ / ____

For intermittent or reduced day leave:

Manager/Supervisor Signature _____ Date ____ / ____ / ____

Human Resources Signature _____ Date ____ / ____ / ____

Notes Doctor appointments should be scheduled as late in the work day as possible. The HR department must be notified in advance of all scheduled appointments.

Payroll Instructions

____ With pay from ____ / ____ / ____ to ____ / ____ / ____

____ Without pay from ____ / ____ / ____ to ____ / ____ / ____

Comments: _____

Certification of Physician
or Practitioner
(Family and Medical Leave Act of 1993)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



1. Employee's Name	2. Patient's Name (If other than employee)
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3. Diagnosis

4. Date condition commenced	5. Probable duration of condition
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6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment, if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)

a. By Physician or Practitioner

b. By another provider of health services, if referred by Physician or Practitioner

If this certification relates to care for the employee's seriously-ill family member, skip Items 7, 8 and 9 and proceed to items 13 thru 20 on reverse side. Otherwise, continue below.

Check **Yes** or **No** in the boxes below, as appropriate

7. Is inpatient hospitalization of the employee required? Yes No

8. Is employee able to perform work of any kind? (If "No", skip Item 9) Yes No

9. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee) Yes No

10. Signature of Physician or Practitioner	11. Date	12. Type of Practice (Field of Specialization, if any)
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For certification relating to care for the employee's seriously-ill family member, complete items 13 through 17 below as they apply to the family member and proceed to item 20.

13. Is inpatient hospitalization of the family member (patient) required? Yes No
14. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? Yes No
15. After review of the employee's signed statement (See Item 17 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) Yes No
16. Estimate the period of time care is needed or the employee's presence would be beneficial.

Item 17 is to be completed by the employee needing family leave

17. When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule.

18. Employee Signature

19. Date

20. Signature of Physician or Practitioner

21. Date

22. Type of Practice (Field of Specialization, if a