

REQUEST FOR EDUCATIONAL LEAVE

DEACONESS HEALTH SYSTEM, INC.

Evansville, Indiana

Date _____

I.D. Number _____

Name _____

Date of Hire _____

Dept./Unit _____

Authorized Hours _____

All employees are eligible to apply for an Educational Leave of Absence if they have been employed at Deaconess Health System for at least six months. Educational Leaves of Absence can be applied for each semester or taken in six-month increments.

All Educational Leave of Absence requests must be discussed and approved by the employee's supervisor.

Please Complete The Following:

I am requesting an Educational Leave beginning on _____ and expect this leave to
(Date)

continue until on or about _____. I will be attending courses at _____
(Name of Institution)

and will verify this by submitting my grade report to my supervisor upon completion of my Educational Leave of Absence.

1. ____ I will be working a reduced schedule of _____ hours per pay period.

2. ____ I do not plan on working during my Educational Leave of Absence.

SELECT BENEFITS TO BE PAID

PAY CODES TO BE ENTERED BY SUPERVISOR

1. PTO Hours to be paid _____ Pay Code PTO

Please **review** the back of this request and **sign** the conditions of the leave that applies to your situation.

Section A applies to employees on Educational Leave who will work 40 hours or more per pay period.

Section B applies to employees on Educational Leave who will work **less** than 40 hours per pay period.

(OVER)

Section A: Employees on Educational Leave working 40 hours or more per pay period:

I understand that if I work a reduced schedule of at least 40 hours per pay period:

1. There will be no charge for my Basic Life Insurance.
2. My Long Term Disability Insurance will not be canceled (if applicable).
3. My Short Term Disability Insurance will not be canceled (if applicable).
4. My insurance premiums will continue to be deducted from my pay checks.
5. If I do not receive pay during my Educational Leave, it will be necessary for me to mail my insurance premiums to the Benefits Section of the Human Resources Department. Failure to make these payments will result in cancellation of my insurance benefits.
6. I will continue to earn PTO based on the number of hours that I am paid while I am on an Educational Leave of Absence.

Signature

Date

Section B: Employees on Educational Leave working less than 40 hours per pay period:

I understand that if I work less than 40 hours per pay period:

1. I will be charged for my Basic Life Insurance.
2. My Long Term Disability Insurance will be canceled during my Educational Leave of Absence but will be reinstated upon my return from leave (if applicable).
3. My Short Term Disability Insurance will be canceled during my Educational Leave of Absence but will be reinstated upon my return from leave (if applicable).
4. My insurance premiums will continue to be deducted from my pay checks.
5. If I do not receive pay during my Educational Leave, it will be necessary for me to mail my insurance premiums to the Benefits Section of the Human Resources Department. Failure to make these payments will result in cancellation of my insurance benefits.
6. I will continue to earn PTO based on the number of hours that I am paid while I am on an Educational Leave of Absence.

Signature

Date

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TO BE COMPLETED BY YOUR SUPERVISOR

Per my discussion with _____ on _____,
(Employee's Name) (Date)

_____ I approve _____ I disapprove this request for an Educational Leave of Absence.

Reason for disapproval _____

Signature

Date

Please forward this request to the Human Resources Department.

EDUCATIONAL LEAVES OF ABSENCE ARE PROCESSED THROUGH THE HUMAN RESOURCES DEPARTMENT.