PAID FAMILY LEAVE REINSTATEMENT FORM

REQUEST FOR REINSTATEMENT FOLLOWING APPROVED LEAVE

Please complete this form to request and document reinstatement following your approved Paid Family and Medical Leave. Submit the completed and signed form to the Human Resources department prior to your scheduled return date.

1. EMPLOYEE INFORMATION

FULL NAME

EMPLOYEE ID

DEPARTMENT

JOB TITLE / POSITION

2. LEAVE DETAILS

LEAVE START DATE

ANTICIPATED RETURN DATE

ACTUAL RETURN DATE

TYPE OF LEAVE TAKEN

☐ Paid Family Leave (Bonding/Family Care)

☐ Paid Medical Leave (Own Serious Health Condition)

3. REINSTATEMENT INFORMATION

REINSTATED POSITION / JOB TITLE

REINSTATED DEPARTMENT

SUPERVISOR / MANAGER NAME

WORK SCHEDULE / HOURS PER WEEK

4. EMPLOYEE ACKNOWLEDGMENT & SIGNATURES

I hereby certify that I am returning from an authorized Paid Family/Medical Leave and request reinstatement to my former position or an equivalent position, in accordance with applicable company policies and statutory regulations.

EMPLOYEE SIGNATURE

DATE

AUTHORIZED HR REPRESENTATIVE SIGNATURE

DATE