Leave of Absence (LOA) Request Form

Please complete and return this form to your immediate supervisor 30 days in advance of the LOA you are requesting.

ASSOCIATE INFORMATION

First Name:		Middle:		Last Name:	
Phone:		Emp. #:		Email:	
Street:		Apt/Unt:		City:	
State:		Zip:			
Job Title:		Store/Dept:			

EMERGENCY CONTACTS

Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	

LOA INFORMATION

Leave dates should match health care provider's note.

Request Type:	Select One	Leave Start Date: *Should be the date following the Last Day Worked*	
Last Day Worked:		Expected Return Date:	

INTERMITTENT LOA REQUEST

☐	Check this box to request intermittent leave

For Intermittent Leave: Please describe, in the box below, your intermittent or reduced work schedule request (e.g., "up to 2-3 sick days a month per doctor"). This request needs to be supported by and documented in a current medical certification form from your health care provider.

REASON FOR LOA

Select the primary reason you are requesting LOA from the drop down box below

Select One

BENEFITS DURING LEAVE

YES	NO	
☐	✔	Are you currently enrolled in health insurance with Torrid? If YES choose an option from the drop down menu below. If NO, skip to signature section.

Select One

Please know that it is your responsibility to continue to pay your portion of the premiums for your health insurance while on LOA. Torrid LLC will pay the employer potion of the premium for up to 12 weeks. If your LOA extends beyond 12 weeks, you will then be responsible for paying both the employer and associate premiums for the duration of your LOA.

Request for Leave of Absence (LOA) Form (cont)

SUPPLEMENTAL PAY DURING LEAVE

All LOAs are unpaid by Torrid, LLC. Associates may request PTO hours (Sick, Vacation, Personal Holiday or FTO) to be entered in to either supplement their income or to cover their bi-weekly benefits premiums while on LOA. For associates who qualify and will apply for disability pay, you may request up to 10 hours per pay period to supplement pay while on LOA.
I request to use the following hours:

	Type of PTO:	# of Hours	To cover benefits	Supplemental Pay
	Sick			
	Vacation			
	Personal Holiday			
	FTO (HQ/DC only)			

**Personal Holiday can only be taken in 8 hour increments up to 16 hours (if available on your PTO balance)*

	I have verified that I have the accrued time available

APPROVAL

I understand that the above leave, if granted, may be used only for the purpose described above and use of the leave for any other purpose can be grounds for disciplinary action up to and including termination of employment. I electronically acknowledge I have carefully read the information in this form, thoroughly completed my request for leave of absence, and understand my responsibilities while on leave of absence.

Associate Signature:		Date:	
Supervisor Signature:		Date:	
DM Signature (Stores):		Date:	