Internal Coded: ☐ Initials: ☐

Rio Tinto

# TIME OFF PAYMENT REQUEST

**All Time off payment request forms must be submitted by 9:00am on payroll Mondays. If submitted any later, the form cannot be processed until the next pay period.**

**This form is to be used any time you are away from scheduled work. This form must be submitted within 15 calendar days of the absence.**

## EMPLOYEE INFORMATION

Employee Name: _____ Phone Number: _____ Employee ID #: _____

Employee Type: ☐ Hourly (Represented) ☐ Salaried (Non-Represented) Supervisor: _____

Date(s) of Leave: _____ Shift: ☐ Day ☐ Swing ☐ Graveyard

Return to Work Date: / / ☐ 8 hour ☐ 10 hour ☐ 12 hour

**I understand that this form must be fully completed and signed in order to receive pay for my absence**

**Employee Signature:** **Date:**

## FMLA INFORMATION

**This form is not an application for FMLA**

If FMLA leave is needed, contact MetLife as soon as possible (1-888-620-0999 or www.mybenefits.metlife.com)

Was an FMLA packet approved by HR to cover this absence? ☐ **Yes** ☐ **No**

Was FMLA absence reported to MetLife? ☐ **Yes** ☐ **No** (All intermittent FMLA absences **must** be reported to MetLife)

If absence is covered under FMLA, and your Sick Leave is exhausted, would you like to use Vacation time to pay for the hours missed? ☐ **Yes** ☐ **No**

## ABSENCE THAT DOES NOT REQUIRE PHYSICIAN VALIDATION

☐ **Sick Leave** *(2 days or less)* **Is this leave A.B.109 (Kin-Care)?** ☐ **Yes** ☐ **No** - **If yes:** ☐ Spouse ☐ Child ☐ Parent

Was this leave work-related? ☐ **Yes** ☐ **No** | ☐ **Jury Duty** *(Attach proof)* | ☐ **School Activity** *(Attach proof)*

☐ **Funeral Leave** *(Attach proof)* – Relationship: | ☐ **Other Leave:**

## ABSENCE THAT REQUIRES PHYSICIAN VALIDATION

☐ **Sick Leave for Self (3 days or more)** ☐ **A.B.109 (Kin-Care) (3 days or more)**

**This section is to be completed by Physician's Office**

**Name of Patient:** _____

If A.B.109 (Kin-Care), please state relationship to employee: ☐ Spouse ☐ Child ☐ Parent

I have treated and/or consulted with the above ☐ employee, or ☐ A.B.109 (Kin-Care) patient

If for employee, was this leave work related? ☐ Yes ☐ No

Patient became sick/injured on ___/___/___. The employee is **estimated** to return to work full time on ___/___/___.

| Physician's Signature: | Physician's Name: | Date: |
|---|---|---|
| Phone: | Address (City, State, Zip): | |

Fax completed form to HR at 760-762-7194, or scan and email to Boron.HR@riotinto.com