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PERSONAL LEAVE OF ABSENCE

DATE: _____ **EMPLOYEE:** _____

I hereby request **PERSONAL LEAVE OF ABSENCE**

If a Personal Leave of Absence is granted, I understand the following:

- 1) It will be for a maximum of 90 days.
- 2) The company will not continue to pay my insurance premiums.
- 3) After the first day of an accident or the eighth day of an illness, I may be eligible for Loss of Time benefits (short-term disability). I must apply for these benefits through Human Resources.
- 4) After 90 days of disability, I may be eligible for long-term disability benefits. I must apply for these benefits through Human Resources.
- 5) The company will make every effort to retain my position for 90 days. A personal leave of absence, however, is not in itself a guarantee of continued employment. The company reserves the right to fill my position, as necessary.
- 6) Return to work from Personal Leave of Absence status is contingent upon the availability of an opening for which I am qualified.
- 7) Return to work will be dependent upon a statement from my doctor certifying that I am able to return to my position.

I have received a copy of Ultra Technologies, Inc. Personal Leave of Absence policy. I have read and understand the policy, and have been given an opportunity to have my questions answered by Human Resources.

Initials: _____

LEAVE OF ABSENCE DATES

From: _____ **To:** _____ **Returning On:** _____

SIGNATURES

EMPLOYEE: _____ **DATE:** _____

MANAGER: _____ **DATE:** _____

EXECUTIVE: _____ **DATE:** _____

HUMAN RESOURCES: _____ **DATE:** _____