Boron 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 daysof 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

IF FMLA, Disability or Parental Leave is needed please file Leave claim with Metlife ASAP by calling 888-620-0999

Was absence reported to METLIFE? ☐ **Yes** ☐ **No All absences & intermittent FMLA absences MUST be reported in 2 days**

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 (for FMLA, only)**

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

☐ **Funeral Leave** *(Attach proof)* – Relationship:
Proof must be received within 10 calendar days. _____ ☐ **Other Leave:** _____

ABSENCE THAT REQUIRES PHYSICIAN VALIDATION

☐ **Sick Leave for Self (3 days or more)**

The Company reserves the right to not act on this payment request, unless the Physician's Certificate below is properly completed and submitted to Human Resources.

This section is to be completed by Physician's Office

Name of Patient: _____

I have treated and/or consulted with the above ☐ employee,

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