ALLIANCE COAL AND AFFILIATES
REQUEST FOR FAMILY / MEDICAL LEAVE

The undersigned requests a family/medical leave of absence for the period and reasons shown below.

NAME:	
COMPANY:	DEPT/LOCATION:
SSN:	EMPLOYEE #:
DATE LEAVE STARTS:	DATE TO RETURN:
Type of Leave: [ ] Full-Time [ ] Intermittent - Please describe [ ] Part-Time – Please describe	

REASON FOR FAMILY / MEDICAL LEAVE OF ABSENCE

[ ] Non-occupational illness/injury [ ] Occupational illness/injury [ ] Birth, adoption or foster placement [ ] To care for spouse, child or parent who has a serious health condition	*If I am requesting leave because of my medical condition or to care for my spouse, child or parent who has a serious medical condition, I will provide a Certification of Physician or Practitioner unless waived by my Local Benefits Coordinator. (A copy of the Certification is available from the Local Benefits Coordinator.) Such Certification must be provided as soon as practical after I submit this Request. Failure to provide the Certification may result in a denial of leave under the Family and Medical Leave Act. I understand the Company may require me to provide additional Certifications.*

BENEFITS

If I am approved for leave under the Family Medical Leave Act, I am entitled to up to 12 weeks of leave of absence, which includes available paid time off due to my disability, if applicable. I understand that I may continue coverage under the Company's employee benefit plans during any approved leave. I may continue to make any payments which would otherwise be required if I were not on such leave of absence or re-pay the Company for my share of the cost when I return from leave.

OTHER CONDITIONS

I understand that a leave of absence, if approved, is granted on the following conditions, unless applicable state law requires otherwise:

- If my leave is approved and covered under the Family and Medical Leave Act, the Company will try to restore me to the same position I had, or if business reasons dictate otherwise, to an equivalent position with equivalent benefits, pay and other terms and conditions of employment.
- However, if my leave is approved, but is NOT subject to the Family and Medical Leave Act, the Company will try to provide a position upon return to work after an approved leave of absence. However, reinstatement to a position and/or at the same salary is not guaranteed.
- I understand any short-term disability leave and workers' compensation leave when applicable will run concurrently with any approved FMLA leave.
- I understand that I may use my available vacation time to continue my pay during an otherwise unpaid leave. I also understand the Company will [ ] will not [ ] require me to use my accrued vacation time.
- I understand that I must return to work on the first day following the expiration of my approved leave, otherwise, my employment may be terminated.
- If I am on medical leave, I understand I must obtain a release to return to work from my physician and the Company may also require a physical examination by another physician.
- Any requests for extensions of the approved leave of absence must be received in writing within 14 days prior to the expiration of the original leave or as soon as possible.

Employee Signature	Date

TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT

		YES	NO
1.	Has the employee been employed at least one year?	_____	_____
2.	Are hourly records kept for this employee?	_____	_____
	If yes, did the employee have at least 1,250 work hours in the last 12 months preceding the requested leave commencement?		
	If no, the employee is presumed to have worked 1,250 hours.		
3.	Does this employee work in a site that has at least 50 employees?	_____	_____
	If no, are there a total of 50 employees within a 75 mile radius?	_____	_____
4.	Is this employee eligible for leave under the Family and Medical Leave Act?	_____	_____

REQUEST FOR FAMILY/MEDICAL LEAVE IS:

[ ] APPROVED [ ] DENIED

Reason:

_____

_____

_____

_____

Date: _____ Human Resource Manager _____

Notification sent to:

Department Manager: _____ Date: _____

Supervisor: _____ Date: _____

Copy to: Employee

Revised 4/11