HALIFAX EMPLOYERS ASSOCIATION
SERVING THE PORT OF HALIFAX SINCE 1996

Medical Leave With Pay Request Form

To be eligible for paid Medical Leave pursuant to Section 239 of Division XIII of ***Part III of the Canada Labour Code*** an employee must have been continuously employed for a period of 30 days and be a Union member, Cardboard or Preferred list member, or an oriented Trainee on the Dispatch List or Checker Trainee List. Probationary employees and Apprentices represented by Local 1825 with 30 days continuous service are also eligible.

- Employees on workforces must have "regular" orders with their parent company on the day(s) for which the leave is requested. Lines, replacement, and fill-in orders are not considered regular orders.

- Gang members who may have "regular" orders with an "outside" employer are also eligible for the Leave provided they advise that employer or their foreman before the start of the shift that they will be taking the Leave.

- Non-attached Union members, members of the Cardboard, Preferred List, Dispatch List, Checker Preferred List, Local 1825 represented Probationary employees and Apprentices **must be able to demonstrate** that, had it not been for their injury or illness, medical appointment, organ donation or quarantine they would have obtained work on the day in question.

Employees who are on leave are not eligible for any other ***regular*** orders for the entire day claimed (from 08h00 on the day claimed to 08h00 the next day) as the leave must be taken in increments of 1 full day.

I am requesting paid Medical Leave pursuant to Section 239 of Division XIII of ***Part III of the Canada Labour Code*** for the following reason:

1. Personal Illness or injury ☐
2. Medical appointment for myself during working hours ☐
3. My organ or tissue donation ☐
4. My Quarantine ☐

NOTE: ***Any employee claiming medical leave for 5 consecutive days or more*** must provide A medical certificate from a qualified health care practitioner certifying that the employee was ***incapable of working for the period of their medical leave***. This certificate should be provided no later than 15 calendar days from the date of the request for Medical Leave unless it is unreasonable to do so for reasons beyond the control of the employee. Medical leave will not be approved retroactively. **NO SICK LEAVE WILL BE PAID UNLESS THE BOX BELOW IS CHECKED.**

☐ ***By checking this box, I confirm that the information in this form is true and correct and that I meet the necessary requirements to be eligible for Paid Medical Leave. I understand that misrepresenting any information on this form is an act of dishonesty and fraud that may lead disciplinary action up to an including termination.***

Employee Name and Work Number: _____

Date(s) Requested _____ **Date Submitted** _____

Signature _____