

## Paid Family Leave Form

### Bond with a newborn, a newly adopted or fostered child

- Complete Form PFL-1**
  - Employee completes PFL-1, Part A.
  - Employee provides PFL-1 to employer.
  - Employer completes PFL-1, Part B.
- Complete Form PFL-2**
  - Employee completes PFL-2 and collects supporting documentation.
- Send forms and documents**
  - Employee sends completed forms and supporting documentation to employer.
  - Employer sends completed forms and supporting documentation to Plan Administrator within three days by electronic mail to 1199PFL@AmalgamatedBenefits.com or by facsimile to (914) 367-5374.
  - Plan Administrator accepts or denies claim within 18 days.

### Care for a family member with a serious health condition

- Complete Form PFL-1**
  - Employee completes PFL-1, Part A.
  - Employee provides PFL-1 to employer.
  - Employer completes PFL-1, Part B.
- Complete Form PFL-3**
  - Care recipient or authorized representative completes PFL-3 and provides to care recipient's healthcare provider.
  - Care recipient's healthcare provider keeps PFL-3.
- Complete Form PFL-4**
  - Employee completes "Employee" information at the top of PFL-4.
  - Employee provides PFL-4 to care recipient's healthcare provider.
  - Care recipient's healthcare provider completes PFL-4 and returns to employee.
- Send forms and documents**
  - Employee sends completed forms and supporting documentation to employer.
  - Employer sends completed forms and supporting documentation to Plan Administrator within three days by electronic mail to 1199PFL@AmalgamatedBenefits.com or by facsimile to (914) 367-5374.
  - Plan Administrator accepts or denies claim within 18 days.

### Assist family members due to another family member's active military duty or impending active duty abroad

- Complete Form PFL-1**
  - Employee completes PFL-1, Part A.
  - Employee provides PFL-1 to employer.
  - Employer completes PFL-1, Part B.
- Complete Form PFL-5**
  - Employee completes PFL-5 and collects supporting documentation.
- Send forms and documents**
  - Employee sends completed forms and supporting documentation to employer.
  - Employer sends completed forms and supporting documentation to Plan Administrator within three days to electronic mail to 1199PFL@AmalgamatedBenefits.com or by facsimile to (914) 367-5374.
  - Plan Administrator accepts or denies claim within 18 days.

Please keep a copy of all pages for your records.

# Request for Paid Family Leave (Form PFL-1) Instructions

- To request PFL, the employee requesting PFL must complete Part A of the *Request for Paid Family Leave (Form PFL-1)*. All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request for Paid Family Leave (Form PFL-1)* and returns it to the Plan Administrator within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request for Paid Family Leave (Form PFL-1)* with the required additional form and supporting documentation to the employer. The employee should retain a copy of each submitted form and supporting document for his or her records.

## PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting PFL must complete all required information.

### Paid Family Leave (PFL) Request (to be completed by the employee)

**Question 12:** A “Child” is defined as a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis. A “Parent” is defined as a biological, foster or adopted parent, parent-in-law, a stepparent, a legal guardian or other person who stood in loco parentis to the employee when the employee was a child.

**Question 13:** If dates are “Continuous,” the employee must provide the start and end dates of the requested PFL. These dates should be the actual dates that the PFL will begin and end. If uncertain, estimate the start and end dates and indicate “Dates are estimated.” If dates are “Periodic,” enter the dates PFL will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate “Dates are estimated.”

If dates are estimated, the Plan Administrator may require you to submit a request for payment after the PFL day is taken. Payment for approval claims will be due as soon as possible but in no event more than 18 days from the date of the completed request.

**Question 14:** If the employee is submitting the PFL request to his or her employer with less than 30 days’ advance notice from the start date of the PFL, the employee must explain why 30 days’ notice could not be given. If the explanation will not fit in the space provided on the form, enter “See Attached” and add an attachment with the explanation. Be sure to include the employee’s full name and his or her date of birth at the top of the attachment.

### Employment Information (to be completed by the employee)

**Question 16:** Enter the date of hire to the best of the employee’s recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

**Question 18:** Enter the best estimate of average gross weekly wage. Include only the wages earned from the employer listed on this request form. **The gross weekly wage is the total weekly pay — including overtime, tips, bonuses and commissions — before any deductions are made by the employer,** such as federal and state taxes. If the employer is not able to supply this information, the employee can calculate his or her gross weekly wage as follows:

**Step 1:** Add all gross wages received (before any deductions) over the last eight weeks prior to the start of PFL, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

**Step 2:** Divide the gross wages calculated in Step 1 by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

**Step 3:** If the employee received bonuses and/or commissions during the 52 weeks preceding PFL, add the prorated weekly amount to the average weekly wage calculated in Step 2. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

#### Example of a gross weekly wage calculation:

Week 1 - Gross wage, including overtime	\$550
Week 2 - Gross wage	\$500
Week 3 - Gross wage	\$500
Week 4 - Gross wage	\$500
Week 5 - Gross wage	\$500
Week 6 - Gross wage	\$500
Week 7 - Gross wage, including overtime	\$600
Week 8 - Gross wage, including overtime	+ \$550
Total =	\$4,200
Divide by 8	÷ 8
Average Weekly Wage =	\$525
Bonus earned in preceding 52 weeks	\$2,600
Divide by 52	÷ 52
Prorated Weekly Bonus =	\$50
Average Weekly Wage	\$525
Plus Prorated Weekly Bonus	+ \$50
<b>Average Weekly Wage (including bonus) =</b>	<b>\$575</b>

Please note that the employer is also required to provide this information in Part B of the *Request for Paid Family Leave (Form PFL-1)*.

*Form PFL-1 Instructions continued on next page*

**PART A - EMPLOYEE INFORMATION (to be completed by the employee) - continued from prior page***Form PFL-1 Instructions continued from prior page*

**The 1199SEIU National Benefit Fund does not accept pre-submission of claims.** Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. The Plan Administrator will return pre-submitted Requests for Paid Family Leave within five days to the employee with an explanation that the claim should be resubmitted when all information is available.

**Employee signs and dates before giving this form to his or her employer to complete Part B.**

**PART B - EMPLOYER INFORMATION (to be completed by the employer)**

**The employer of the employee requesting PFL must complete all information in Part B.**

**Question 2:** If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

**Question 3:** Enter the employer's Standard Industrial Classification (SIC) Code. Contact your Plan Administrator if you don't know your SIC code.

**Question 8:** The employee occupation code can be found at [www.BLS.gov/SOC/2018/Major\\_Groups.htm](http://www.BLS.gov/SOC/2018/Major_Groups.htm).

**Question 9:** Enter the wages earned by the employee during the last eight weeks preceding the PFL start date. The gross amount paid is the employee's gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 18 on page 1 of the instructions.) Calculate the gross average weekly wage by adding up the gross amounts paid, and then divide by eight (or number of weeks worked if less than eight).

**Question 10:** "NYS Disability" refers to NYS statutory-required disability. If the answer to this question is "None," then enter a "0" for total numbers of "Weeks" and "Days" in Question 10a.

**Question 10a:** The maximum number of weeks available for NYS statutory disability and PFL in any 52-week period is 26 weeks. Specify the total number of "Weeks," as well as the number of additional "Days" if the leave includes a partial week, taken for NYS statutory disability and PFL during the preceding 52 weeks.

**Questions 12 & 13:** Enter the Paid Family Leave or Disability/PFL Plan Administrator's name, address and PFL telephone number. If this employer is self-insured, enter the name and address of where the PFL request should be submitted for processing.

**Affirmation employee is eligible for PFL:** An employee must have been in employment for at least 26 consecutive weeks.

**Employer signs and dates. Submit completed forms and supporting documentation to the Plan Administrator within three days by electronic mail to [1199PFL@AmalgamatedBenefits.com](mailto:1199PFL@AmalgamatedBenefits.com) or by facsimile to (914) 367-5374.**

Be sure to complete the appropriate additional PFL form(s) based on the type of PFL being requested.

**Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).**

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or taxpayer identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or taxpayer identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

# Request for Paid Family Leave (Form PFL-1)

INSTRUCTIONS INCLUDED WITH FORM

## PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)

2. Other last names, if any, under which employee has worked

3. Employee's mailing address

STREET ADDRESS

CITY

STATE

ZIP CODE

COUNTRY (IF NOT U.S.A.)

4a. Employee's Social Security Number or Taxpayer Identification Number (TIN)

4b. Employee's 1199SEIU Health Benefits ID card number

5. Employee's date of birth (MM/DD/YYYY)

6. Employee's primary telephone number

7. Employee's preferred email address while on PFL (if available)

8. Employee's gender

Male  Female  Not designated/Other

9. Employee's preferred language

English  Español  Polski  русский  
 한국어  中文  Italiano  Kreyòl Ayisyen  
 Other (specify):

### Optional (for research purposes)

10. Employee's ethnicity/race

For purposes of health demographics only. (U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0.)

Is employee of Hispanic, Latino/a or Spanish origin?

(One or more categories may be selected.)

- Mexican  
 Mexican American  
 Chicano/a  
 Puerto Rican  
 Dominican  
 Cuban  
 Another Hispanic, Latino/a or Spanish origin  
 Not of Hispanic, Latino/a or Spanish origin  
 Unknown

What is employee's race?

(One or more categories may be selected.)

- American Indian or Alaska Native  
 Black or African American  
 Asian Indian  
 Chinese  
 Filipino  
 Japanese  
 Korean  
 Vietnamese  
 Other Asian  
 White  
 Native Hawaiian  
 Guamanian or Chamorro  
 Samoan  
 Other Pacific Islander  
 Other race

## Paid Family Leave (PFL) Request (to be completed by the employee)

11. Reason for PFL request:  Bond with child  Care for family member  Military qualifying event

12. The family member is employee's:

Child  Spouse  Domestic partner  Parent  Parent-in-law  Grandparent  Grandchild  Sibling

Form PFL-1 continued on next page



**TO BE COMPLETED BY THE EMPLOYEE**

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

**PART A - EMPLOYEE INFORMATION (to be completed by the employee) - continued from prior page**

*Form PFL-1 continued from prior page*

13. Will PFL be for a continuous period of time and/or periodic?

- Continuous PFL start date (MM/DD/YYYY) \_\_\_\_\_ PFL end date (MM/DD/YYYY) \_\_\_\_\_  Dates are estimated
- Periodic Identify start and end date that periodic PFL will be taken \_\_\_\_\_  Dates are estimated

14. If providing less than 30 days' advance notice to the employer, please explain:

**Employment Information (to be completed by the employee)**

15. Business name

16. Employee's date of hire (MM/DD/YYYY)

17. Employee's work location

STREET ADDRESS

CITY

STATE

ZIP CODE

COUNTRY (IF NOT U.S.A.)

18. Employee's average gross weekly wage (this data will be requested of both employee and employer) \_\_\_\_\_

19. Employer's telephone number for contact regarding this request \_\_\_\_\_

20. Does employee have more than one employer?  Yes  No

20a. If "Yes," is employee taking PFL from the other employer?  Yes  No

20b. Is employee currently receiving Workers' Compensation Lost Wage Benefits?  Yes  No

20c. Name and address of other employer (if applicable)

**Disclosure statement:** Information regarding PFL benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

**Declaration and signature**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for Paid Family Leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

EMPLOYEE'S SIGNATURE

DATE SIGNED (MM/DD/YYYY)

**TO BE COMPLETED BY THE EMPLOYEE**

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

**PART B - EMPLOYER INFORMATION (to be completed by the employer)**

**1. Business' full legal name and mailing address**

BUSINESS NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

COUNTRY (IF NOT U.S.A.)

2. Employer's Federal Employer Identification Number (FEIN) \_\_\_\_\_

3. Employer's Standard Industrial Classification (SIC) Code \_\_\_\_\_

4. Employer's contact name for questions related to PFL \_\_\_\_\_

5. Employer's contact telephone number \_\_\_\_\_

6. Employer's contact email address \_\_\_\_\_

7. Employee's date of hire (MM/DD/YYYY) \_\_\_\_\_

8. Employee's occupation (Codes are available at [www.BLS.gov/SOC/2018/Major\\_Groups.htm](http://www.BLS.gov/SOC/2018/Major_Groups.htm).) \_\_\_\_\_

**9. Enter the last 8 weeks of gross wages for the employee and calculate the average gross weekly wage:**

Week no.	Week ending date (MM/DD/YYYY)	Number of days	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
Calculated average gross weekly wage:			

10. If employee received or will receive full wages while on PFL, will employer be requesting reimbursement?  Yes  No

*Form PFL-1 continued on next page*

<b>TO BE COMPLETED BY THE EMPLOYEE</b>	
Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

**PART B - EMPLOYER INFORMATION (to be completed by the employer) - continued from prior page**

*Form PFL-1 continued from prior page*

11. In the preceding 52 weeks, has the employee taken leave for:  NYS Disability     PFL     Both Disability and PFL     None

11a. Enter the total number of weeks and days taken for both Disability and PFL in the last 52 weeks:

Please provide specific dates for Disability:

**Disability:**    Weeks \_\_\_\_\_

Days \_\_\_\_\_

Please provide specific dates for PFL:

**PFL:**    Weeks \_\_\_\_\_

Days \_\_\_\_\_

12. Is the employee taking Family Medical Leave Act (FMLA) concurrently with PFL?     Yes     No

13. PFL Plan Administrator's name and mailing address

**1199SEIU National Benefit Fund for Health and Human Service Employees**

PFL PLAN ADMINISTRATOR'S NAME

**498 Seventh Avenue**

STREET ADDRESS

<b>New York</b>	<b>NY</b>	<b>10018-0009</b>	
CITY	STATE	ZIP CODE	COUNTRY (IF NOT U.S.A.)

14. PFL Plan Administrator's telephone number (646) 473-9200

15. PFL policy number \_\_\_\_\_



**Declaration and signature**

I affirm the employee is a Wage Class I, II or III employee who is enrolled in the 1199SEIU National Benefit Fund and has been in employment for at least 26 consecutive weeks.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am the person authorized to sign as the employer of the employee requesting Paid Family Leave benefits under the NYS Workers' Compensation Law. My signature affirms that to the best of my knowledge and belief, the information I have provided is true and accurate.

EMPLOYER'S AUTHORIZED SIGNATURE	DATE SIGNED (MM/DD/YYYY)
TITLE	



# Military Qualifying Event (Form PFL-5) Instructions

If an employee is requesting PFL because of a family member's covered active military duty or impending covered active duty, the employee must submit the *Military Qualifying Event (Form PFL-5)* with the *Request for Paid Family Leave (Form PFL-1)*.

The employee must identify the family member, provide a copy of the member's covered active duty orders or impending active duty orders, and describe the reason leave is being requested.

## MILITARY QUALIFYING EVENT (to be completed by the employee)

**The employee requesting PFL must complete all required information.**

Employee enters his or her name, date of birth, other last names, if any, under which he or she has worked, Social Security Number or Taxpayer Identification Number (TIN) and mailing address at the top of page 1.

Employee enters his or her name and date of birth at the top of page 2.

**Questions 1-5:** Enter the military member's information, and indicate the military member's relationship to the employee.

**Question 5:** A "Child" is defined as a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis. A "Parent" is defined as a biological, foster or adoptive parent, parent-in-law, a stepparent, a legal guardian or other person who stood in loco parentis to the employee when the employee was a child.

**Question 6:** Enter the dates of expected military covered active duty.

**Question 7:** Documentation that shows that the military member is on covered active duty or has been notified of an impending call or order to covered active duty is required and must be attached to this form. Select the type of documentation to be attached from the list below.

Required documentation includes one of the following:

- Covered active duty orders; OR
- Letter from the military unit documenting impending call or order to covered active duty; OR
- Documentation of military leave signed by the approving authority for military member's Rest and Recuperation.

## Qualifying Reason for Leave (to be completed by the employee)

**Question 8:** Explain the need for PFL because of the Military Qualifying Event. For example: "My spouse was just called on short notice to covered active duty status, and will be deployed to (country) in five days. I need to take PFL to be with my spouse and make arrangements for while he or she is away on active duty." If the explanation will not fit in the space provided on the form, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name, date of birth, other last names, if any, under which he or she has worked, Social Security Number or Taxpayer Identification (TIN), and mailing address at the top of the attachment.

**Question 9:** Include one or more of the qualifying supporting documents.

- Copy of meeting announcement for an international briefing sponsored by the military; OR
- A document of military leave signed by the approving authority for military member's Rest and Recuperation; OR
- A document confirming an appointment with a third party, such as a school official, doctor, attorney or financial advisor; OR
- Copy of a bill for services for the handling of legal or financial affairs.

### Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or taxpayer identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or taxpayer identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.





# Request for Paid Family Leave Military Qualifying Event (Form PFL-5)

INSTRUCTIONS INCLUDED WITH FORM

**TO BE COMPLETED BY THE EMPLOYEE**

Employee's name (first name, middle initial, last name)		Employee's date of birth (MM/DD/YYYY)	
Other last names, if any, under which employee has worked		Employee's Social Security Number or Taxpayer Identification Number (TIN)	
Employee's mailing address			
STREET ADDRESS			
CITY	STATE	ZIP CODE	COUNTRY (IF NOT U.S.A.)

**MILITARY QUALIFYING EVENT (to be completed by the employee)**

1. Name of military member on covered active duty or impending call to covered active duty status (international deployment)  
(first name, middle initial, last name)

2. Military member's date of birth (MM/DD/YYYY)

3. Military member's gender  Male  Female  Not designated/Other

4. Military member's mailing address

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY (IF NOT U.S.A.)

5. The above-named military member is employee's:  Spouse  Domestic partner  Child  Parent

6. Period of military member's covered active duty (MM/DD/YYYY)

FROM TO

7. Please select one of the following and attach the indicated document to support that the military member is on covered active duty or impending call or order to covered active duty status:

Covered active duty orders  Letter of impending call or order to covered active duty  Documentation of military leave signed by the approving authority for military member's Rest and Recuperation

**Qualifying Reason for Leave (to be completed by the employee)**

8. What is the reason employee is requesting PFL? (One or more reasons may be selected.)

Arranging for child care  Acting as military member's representative before a federal, state or local agency for purpose of obtaining, arranging or appealing military service benefits

Arranging for parental care  Attending any event sponsored by the military or military service organizations

Counseling  Other (specify):

Making financial arrangements

Making legal arrangements

Form PFL-1 continued on next page



**TO BE COMPLETED BY THE EMPLOYEE**

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

**MILITARY QUALIFYING EVENT (to be completed by the employee)***Form PFL-5 continued from prior page***9. Is written documentation supporting this request for leave available and attached?**
 Yes     No     None available

Note: A complete and sufficient certification to support a request for PFL due to a qualifying event includes any available written documentation which supports the need for leave. Such documentation may include: a copy of a meeting announcement for an informational briefing sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. If leave is requested to meet with a third party, the employee must provide the supporting documentation of the meeting that includes the name, address and appropriate contact information of the individual or entity with whom the employee is meeting (i.e., either telephone number, fax number, or email address of the individual or entity).

**Declaration and signature**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I am hereby making a request for Paid Family Leave benefits under the NYS Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

EMPLOYEE'S SIGNATURE

DATE SIGNED (MM/DD/YYYY)

**TO BE COMPLETED BY THE EMPLOYEE**

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

Other last names, if any, under which employee has worked

Employee's Social Security Number or Taxpayer Identification Number (TIN)

Employee's mailing address

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY (IF NOT U.S.A.)

**QUALIFYING REASON FOR LEAVE DOCUMENTATION**

If leave is requested to meet with a third party, the employee must provide supporting documentation of the meeting that includes the name, address and appropriate contact information of the individual or entity with whom the employee is meeting (i.e., either the telephone number, fax number or email address of the individual or entity). The reason for a meeting can include: arranging for child or parental care; counseling; making financial or legal arrangements; acting as the military member's representative before a federal, state or local agency for purposes of obtaining, arranging or appealing military service benefits; or attending any event sponsored by the military or military service organizations.

**Please submit this documentation for each required meeting/event.**

Name of individual with whom employee is meeting

Title

Organization

Telephone number (provide area or country code)

Fax number (provide area or country code)

Email address

Mailing address

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY (IF NOT U.S.A.)

Describe nature of meeting, including dates, if known:

