



Request for Leave of Absence

TO BE COMPLETED BY EMPLOYEE

Name:		Location/Div.:	
Home Telephone #:		Cell #:	
		Personal Email:	

A. Leave of Absence Category:

<input type="checkbox"/>	Medical Leave (Employee–FMLA)	<input type="checkbox"/>	Pending Workers’ Compensation Claim
<input type="checkbox"/>	Medical Leave (Family Member - FMLA)	<input type="checkbox"/>	Military Training / Active Duty
<input type="checkbox"/>	<p>Emergency FMLA Leave (temporary special leave program; benefits are provided to the extent required by Emergency Family and Medical Leave Expansion Act)</p> <p>Employee is unable to work or telework (in an assigned office or at an alternate work site) due to a need to care for the employee’s child, step-child, or placed foster child under 18 years of age if the child’s/children’s school or place of care has been closed, or the child’s or children’s care provider is unavailable, as a result of a federal, state, or local declaration of emergency related to the COVID-19 virus.</p>	<input type="checkbox"/>	<p>Emergency Paid Sick Leave (temporary special leave program; benefits are provided to the extent required by specially adopted Emergency Paid Sick Leave Act)</p> <p>Employee is unable to work (in an assigned office or at an alternate work site) because (pick one or more):</p> <p><input type="checkbox"/> Employee is subject to a Federal, State, or local quarantine or isolation order related to COVID–19</p> <p><input type="checkbox"/> Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID–19</p> <p><input type="checkbox"/> The employee is experiencing symptoms of COVID–19 and is seeking a medical diagnosis</p> <p><input type="checkbox"/> The employee is caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID–19, or is a caring for an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID–19</p> <p><input type="checkbox"/> The employee is caring for the employee’s child, step-child, or placed foster child under 18 years of age if the child’s/children’s has been closed, or the child care provider of such son or daughter is unavailable, due to COVID–19 precautions.</p> <p>NOTE: If you are checking this box, please also check the Emergency FMLA Leave box</p> <p><input type="checkbox"/> The employee is experiencing symptoms substantially similar to those specified by the Secretary of Health and Human Services as attributable to the Covid19 virus</p>
<input type="checkbox"/>	Pregnancy Leave (Employee)	<input type="checkbox"/>	Military Exigency Leave for Family Member’s Active Duty
<input type="checkbox"/>	Child Birth / Foster Parent / Adoption Leave (Employee)	<input type="checkbox"/>	Personal Hardship / Special non-Medical Leave (including medical leaves if you do not qualify under FMLA or similar laws)
<input type="checkbox"/>	State/Local Leave Law		

Personal Employee Medical/Pregnancy Medically necessary leave for your serious health condition or pregnancy. **Certification of Health Care Provider for Employee’s Serious Health Condition Form is required.**

Family Medical Leave necessary to provide care for a family members’ serious health condition. **Certification of Health Care Provider for Family Member’s Serious Health Condition Form is required.**

Child Birth/Foster Parent/Adoption Leave A request for leave to care or bond with (i) a new born child, (ii) a foster child placed with you by the County or State, or (iii) a child actually placed with you for adoption by a public or private agency. **Evidence of birth or placement is required.**

Pending Workers’ Compensation Claim A request for leave addressing a claimed workplace injury, rendering you medically unable to perform your job duties, that will remain in effect until the claim is accepted for workers’ compensation coverage, at which time

leave and return to work issues will be processed under the workers' compensation system. If the claim is denied, leave/continuing leave issues will be addressed under the Personal Employee Medical leave provisions.

Military Training/Active Duty/Military Exigency A leave related to your call to required training/active duty in the U.S. Armed Forces or Reserves, or, in certain circumstances, a family member's call to duty. **Verification of training or call to duty is required.**

Personal Hardship/Non-Necessary Medical Leave A leave to address special or unexpected personal hardships or situations or medical leaves in cases where you do not qualify for applicable federal, state, and/or local leaves. The request may also involve "non-necessary" medical conditions or procedures (repair of facial scars, for example). Each request will be evaluated on a case-by-case basis, considering company business needs during the requested leave period, and other relevant facts or circumstances. **Appropriate documentation may be required.**

State/Local Law Leave (Not covered under another Leave program) A leave available under **State or local laws/ordinances governing the physical location in which you work**, potentially including domestic violence/assault, bereavement, jury duty/witness, religious observance, voting, domestic violence/crime victim, public agency emergency assistance and volunteer firefighter, school visits (parent-teacher conference/ suspended student), organ/ bone marrow donation, or English literacy leaves. **Appropriate documentation is required.**

C. I request the following type(s) of leave period(s) (designate One or More Leave Types from the Following Categories):

1. Continuous (<i>Days/Weeks/Months</i>)	Starting Date:	Ending Date:	
2. Intermittent (<i>Every Friday; 1 hr. ea. Fri., or alternating days</i>)	Starting Date:	Anticipated Days/Periods:	Ending Date:
3. Modified Schedule (<i>6-hour days, 3 days/week</i>)	Reduce work week/hours to:	Starting Date:	Ending Date:

B. Benefits Continuation: **You are solely responsible for your Premium Contribution Obligations

<input type="checkbox"/>	Bill me for my contribution toward my insurance premiums. For the period of my approved leave of absence, I will be billed on a monthly basis for my contribution, and I agree to make payments directly to _____.
<input type="checkbox"/>	Deduct my contribution toward my insurance premiums via payroll deduction while I am receiving ongoing income (i.e. Paid Sick, to the extent available, vacation, Emergency Paid FMLA Leave). If I exhaust all available paid leave benefits, I will be billed on a monthly basis for my contribution, and I agree to make payments as directed.

For leave periods involving 5 or more consecutive days, **if you will not be at your home address and telephone number**, please provide the following:

Alternate Telephone:	Alternate Address:	Special Emergency Contact (if applicable):
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Complete this Section only for: Personal, Family, Medical, or Pregnancy Leave Requests:

1. I am requesting a Personal or Family Medical Leave and/or Pregnancy Leave Based on (Check Each Applicable Box):

<input type="checkbox"/>	My Serious Health Condition	<input type="checkbox"/>	A Serious Medical Condition of my Spouse/Domestic, Parent, Child, or Active Duty Military Next of Kin
<input type="checkbox"/>	My Pregnancy	<input type="checkbox"/>	Foster Parent/Adoption Leave (Employee)

2. In addition to a qualifying situation checked above:

<input type="checkbox"/>	My spouse/domestic partner:	<input type="checkbox"/> is employed by the Company	<input type="checkbox"/> is also seeking leave under these laws to care for themself/our family member
		<input type="checkbox"/> is not employed by the Company	<input type="checkbox"/> is also seeking leave under these laws to care for themself/our family member

Complete this section only for Emergency Family and Medical Leave Expansion Act Requests

1. I am electing to use following paid leave *during the initial 10 days* of Emergency FMLA leave

<input type="checkbox"/> Emergency Paid Sick Leave <input type="checkbox"/> Accrued Vacation or Sick Leave	<p>NOTE: You may check one or the other, or both You are not required to elect either of these options.</p> <ul style="list-style-type: none"> An eligible employee that elects only Emergency Paid Sick Leave for the initial 10 days is electing to use paid sick leave under the Emergency Paid Sick Leave Act at the rate of pay required by the Act. An eligible employee who elects only accrued vacation or sick leave for the initial 10 days is electing to receive vacation or sick leave according to the Company’s paid leave policy. An eligible employee who elects both Emergency Paid Sick Leave and accrued vacation and sick leave is electing to use Emergency Paid Sick Leave hours and sufficient vacation hours to ensure a full day of pay at the employee’s regular rate. The vacation and sick leave hours used will be deducted from the employee’s accrued vacation and sick leave according to the Company’s leave policy.
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2. I am electing to use the following additional paid leave during the remaining 74 days of Emergency FMLA leave:

<input type="checkbox"/> Emergency Paid Sick Leave <input type="checkbox"/> Accrued Vacation or Sick Leave	<p>NOTE: You may check one or the other, or both You are not required to elect either of these options.</p> <ul style="list-style-type: none"> An eligible employee that does not elect either option is electing to use Emergency FMLA paid leave at the rate of pay required by the law. An eligible employee who elects only accrued vacation or sick leave is electing to use sufficient vacation or sick leave hours according to the Company’s vacation or sick leave policy to ensure a full day of pay at the employee’s regular rate. The vacation or sick leave hours used will be deducted from the employee’s accrued vacation or sick leave according to the Company’s leave policy. An eligible employee who elects both Emergency Paid Sick Leave and accrued vacation or sick leave is electing to combine both kinds of paid leave to ensure that the employee receives the maximum amount of pay, up to a full day of pay at the employee’s regular rate, until Emergency Paid Sick Leave or accrued vacation or sick leave are exhausted.
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Complete this section only for Emergency Paid Sick Leave Act Requests

I am electing to use additional vacation or sick leave during my emergency paid sick leave.

NOTE: You are not required to make this election. However, an eligible employee who makes this election is electing to use Emergency Paid Sick Leave hours and sufficient Vacation hours to ensure a full day of pay at the employee’s regular rate. The vacation will be deducted from the employee’s accrued vacation according to the Company’s leave policy.

Supplemental Income Replacement (All Other Forms of Leaves/Leave Requests)

<input type="checkbox"/>	[If Applicable] During the period of time before any Short-Term or other applicable disability benefits commence, please continue my wages from my available <input type="checkbox"/> Sick Leave; <input type="checkbox"/> Vacation; for supplemental income.
<input type="checkbox"/>	[If Applicable] After the elimination period, please pay me from available <input type="checkbox"/> Sick Leave; <input type="checkbox"/> Vacation; for supplemental income.

I agree to the following additional conditions of my Leave Request (check each box that applies):

<input type="checkbox"/>	If I am requesting and obtaining a job protected leave under federal/state/local leave laws, once the <u>job protected leave expires</u> , I will not be entitled to automatic job reinstatement, or a further leave of absence (although I may be entitled to additional leave benefits under federal or state disability leave laws). In order to determine the maximum period of job protected leave time, any FMLA or similar medical leave time during the last 12 months will be subtracted from the potential statutory leave I may be seeking in this Request. (This condition does not apply to Emergency FMLA leave)
<input type="checkbox"/>	[If Applicable] Absent a written waiver from Human Resources, as quickly as possible, and no later than 15 days after this Request, I must submit directly to Human Resources (i) a Medical Certification Form (for my own or a family member's personal health or medical condition), (ii) evidence of the foster care/adoption placement, or (iii) other official documentation supporting the leave request. Failure to do so may result in my Request being delayed or denied, and may also result in discipline. (This condition does not apply to Emergency FMLA leave)
<input type="checkbox"/>	[If Applicable] If this Request relates to my personal medical or health condition, the Company may have me evaluated by a physician of its choosing, at its expense, as allowed by governing laws to determine if I can safely perform the essential functions of my job (if on intermittent leave/accommodations) and/or whether I am entitled to medical leave. Before I return to work, unless this requirement is expressly waived in writing by Human Resources, I will be required to provide a Return to Work Release to Human Resources signed my health care provider on a Company-approved form. (This condition does not apply to Emergency FMLA leave)
<input type="checkbox"/>	Unless a federal, state or local law or ordinance, or express Company policy states that I am entitled to compensation during the leave period, all leaves are unpaid. The Company will continue my health and welfare benefits for which I am enrolled. For those benefits requiring my contribution, I remain personally responsible for payment. If I fail to return from leave, or if I fail to pay my contribution amount, the Company will cancel my elective benefit coverage.

To the best of my understanding and belief, all of the information set forth above is true and correct. I have read the Important Information Regarding Workplace Leaves and understand my obligations discussed in that Form and in this Request. I agree to comply with all of my obligations. My employment may be subject to discipline or termination, or my leave may be canceled, if I fail to comply with those obligations.

Employee Name	Employee Signature	Date
Received by Human Resources: Name	Signature	Date

Important Information Regarding Workplace Leaves

The following information is provided to assist you in preparing the Request for Leave of Absence form ("Request"):

- Granting of Leaves** - Statutorily authorized workplace absences (FMLA, pregnancy leave, active duty military leave, state law mandated leaves, etc.) will be granted once the Company receives an appropriate, signed Request, which is supported by proper documentation. Other requests will be evaluated on a case-by-case basis in keeping with the reason for the request and the Company's business needs. Leave requests cannot be approved by your supervisor; they must be received and approved by Human Resources.
- Timing of Leave Requests** - Absent a medical emergency, or an urgent and unexpected event (i.e., an emergency placement of an adopted/foster child in your home; an unexpected call to active duty, etc., an Emergency FMLA leave, or an Emergency Paid Sick Leave), all leave requests must be submitted at least **30 days prior** to the proposed leave date. Requests to extend an existing leave of absence should be made as soon as you become aware of a potential need to extend the leave period, and **usually no later than two weeks before the end of the current leave period.** **For urgent or emergency leave situations,** the Request should be submitted as soon as possible, and **the earlier of (a) 15 days after the leave period commences or (2) two work days after your return from leave.** In emergency or unexpected leave situations, the Company may approve a request retroactively to the day of your first absence. **Noncompliance with these obligations may, in compliance with governing laws, result in a denial of the leave request or the imposition of discipline, including termination.**
- Requesting Leave Periods** - As authorized by law, a leave request may involve blocks of time (consecutive days/weeks/months) or intermittent or irregular periods of time (half-days; every Friday, etc.). The nature and extent of the requested leave period(s) should be clearly specified in the Request form, which must be supported by appropriate documentation (Medical Certification, etc.). During the approved leave period, you may request a change in leave designation (i.e., from a full leave, to partial days), based on changed or ongoing circumstances. **Available leave is calculated on a rolling 12 month period looking backward. Leave taken in the previous 12 months will be subtracted to determine total available leave.**
- Contact Human Resources for Information about Benefits, Disability and Other Programs** - Your leave request is unrelated to benefits or obligations you may have under short-term disability, long-term disability, workers' compensation, disability rights laws, or other Company, private or state-sponsored health, welfare, or benefit programs. Contact Human Resources with questions regarding your potential benefits and obligations under these programs.
- Cooperation and Assistance** - Before and during the proposed workplace absence, you must (i) work cooperatively with the Company to evaluate and process this Request, (ii) assist us in meeting workplace needs associated with your planned or continuing absence (including the sharing of passwords, keys, or important information to assist co-workers in your absence), and (iii) keep your supervisor and Human Resources apprised of issues affecting your status and expected return to work date. Failure to timely provide such information and assistance may, under appropriate circumstances, affect your continuing right to approved leave or result in the imposition of discipline, including termination.
- Submission of the Leave Request** - Once you have completed the Request, keep one copy for your records and provide the original signed Request to Human Resources c/o Leave Requests Elizabeth Antiporda at eviceral@pulmonx.com or HRPulmonxUS@pulmonx.com or by mail to Elizabeth Antiporda C/O Pulmonx, 700 Chesapeake Dr., Redwood City, CA 94063). **No Request can be authorized until it is received and approved by Human Resources.** **If an employee is physically unable to complete required forms, his/her representative should advise Human Resources of the event leading to the incapacity and provide supporting information to the Company.** The Company will then evaluate and unilaterally designate the absence as approved to the extent governing leave or disability laws apply to the situation.
- Job Protection.** Your job will be protected if your leave request is granted pursuant to a federal or state leave law. Hardship leaves under are not subject to job protection. The Company may need to replace you or your position while you are on non-job protected leave.
- Non-Discrimination/Non-Retaliation Statement.** The Company will not harass, discriminate, or retaliate against you for seeking or obtaining a leave of absence under federal or state law leave laws. Nevertheless, you may face discipline, including termination, if you: (1) submit, or allow anyone else to submit on your behalf, false or misleading information; (2) take actions inconsistent with the basis for the leave (i.e., taking a pleasure vacation while on medical leave; engaging in alternate work similar to current job duties, etc.); or (3) refuse to participate in early return to work/modified duty programs when physically able to perform such duties.