REQUEST FOR LEAVE OF ABSENCE

Employee: _____ Employee ID: _____

(Please print or type all information)

Department: _____ Division: _____ Job Title: _____

1st Day of Leave *(this date does not change)*: _____ Estimated Return Date *(required)*: _____

Leave Type: Regular ☐ Intermittent ☐ Reduced Schedule ☐ Qualifying Event Date: _____

Est. Date of Birth: _____ Date of Birth or Placement: _____ Date of Release-Pregnancy Disability_____

Extension Effective Date: #1_____ #2_____ #3_____ #4 _____

Extended Return Date: #1_____ #2_____ #3_____ #4 _____

Department Approval: #1_____ #2_____ #3_____ #4 _____

With Pay (Dates): _____ Without Pay (Dates): _____

Reason:

(Column A) Employee	**(Column B)**	**(Column C)**
☐ Work-Related Injury/Illness	☐ Spouse / Domestic Partner Illness/Injury	☐ Military Leave
☐ Non Work-Related Injury/Illness	☐ Dependent Child's Illness/Injury	☐ Education Leave
☐ Pregnancy Disability	☐ Parent's Illness/Injury	☐ Sabbatical Leave
☐ 4850 Leave	☐ Bonding Leave (complete PPL Form)	☐ Other

Current Leave Balances
PPE Date _____
Vac _____
Sick _____
COMP _____
PPL _____

FMLA/CFRA Notice: I have received a copy of the *Notification of Eligibility of Family Medical Leave* that explains my rights and responsibilities under the *Family and Medical Leave Act* and the *California Family Rights Act.*

For Medical Leaves of Absence: I submit with this request the applicable *Medical Certification Form* verifying the need and estimated duration of this medical-related leave. Prior to my leave, I read the *County of Sonoma Medical Leave Policy*. I understand my responsibilities during my medical leave as outlined in the leave policy in **Section III. Responsibilities-Employee**. The policy also includes the obligations I must fulfill if I want to continue my health and medical benefits. **My initials verify that I have read and understand the *County of Sonoma Medical Leave Policy* (_____).**

Retirement Buyback: If I am a member of the Retirement System and my leave is for a reason in Column A or for Military Leave, I understand it may be possible to purchase retirement service credit for unpaid time. I must return to work for at least a full pay period in order to purchase (contact Retirement for complete details regarding return to work). I understand a copy of this completed form will be sent to SCERA and kept with my retirement records. I also understand it will be my responsibility to contact SCERA if I wish to receive a calculation of the cost to purchase this leave without pay to restore lost service credit.

Comments: _____

Employee Signature: _____ Date: _____
(Not required if not available)

DEPARTMENT AUTHORIZATIONS:

Medical Leaves – Applicable entitlements: The employee meets eligibility requirements and this leave qualifies under the following:

(More than one option may apply)

☐ CFRA ☐ FMLA ☐ CPDL ☐ 4850 ☐ FMLA-Military caregiver ☐ Exhausted Entitlements ☐ Not Eligible

Entitlements Verified by HRL: _____ Date: _____

Appointing Authority's
or Designee's Signature: _____ Date: _____ ☐ Approved ☐ Disapprove

Comments: _____

FOR LEAVES OR EXTENSIONS IN EXCESS OF SIX MONTHS WITHOUT PAY:

HR Director/Designee: _____ Date: _____ ☐ Approved ☐ Disapprove

Comments: _____

Leave Extension End Dates: #1_____ #2_____ #3_____ #4 _____

HR Approval: #1_____ #2_____ #3_____ #4 _____

COMPLETION OF LEAVE OF ABSENCE:

The above employee: ☐ returned to full schedule on _____

☐ was terminated or resigned without returning to duty effective: _____

Appointing Authority: _____ Date: _____

cc: Department Medical File
AUD_PAY
Employee
Human Resources *(when required)*
Sheriff's Personnel Bureau
Retirement/Retirement-Military

Department Payroll Contact Name: _____ Phone #: _____