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, 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 #:______________