County of Ventura
Human Resources

Leave of Absence Request
INSTRUCTIONS: After completion, please return this form to your Leave of Absence Coordinator.

SECTION I:

Name (Last, First, Middle):		EE ID:	
Mailing Address (Include Apt/Unit #):			
Home Phone:		Cell Phone:	
Email:		Work Phone:	
Department:		Last Day Worked (month/day/year):	
Supervisor Name:		Supervisor Phone:	
Date Leave Begins:		Date Leave Ends:	Extension: ☐ Yes ☐ No

During this leave or extension, I request: ☐ PAID Leave ☐ UNPAID Leave

Will you be applying for disability benefits during this leave? ☐ Yes ☐ No

Type of Leave Request: ☐ Continuous Leave ☐ Intermittent or Reduced Schedule (Specify schedule below)

SECTION II:

I request a leave of absence for the following reason (check one):

☐ Employee's own serious health condition that makes the employee unable to perform the functions of his/her position.
Is the injury work related? ☐ Yes ☐ No Injury Date:

☐ Disabled by pregnancy or childbirth.
If my Pregnancy Disability Leave (PDL) entitlement exhausts prior to my doctor releasing me to return to work, I wish to use my CFRA (bonding) entitlement immediately after my PDL. ☐ Yes ☐ No Expected due date:

☐ In order to care for an immediate family member because such family member has a serious health condition.
Check one (and provide name): Name:
☐ Spouse ☐ Parent ☐ Domestic Partner ☐ Child/child of domestic partner (under 18 only) Age:

☐ Bonding Leave: Check one: ☐ Newborn ☐ Adoption ☐ Foster Care Placement Date Acquired/Born:

☐ Care for an adult child who is incapable of self-care (A child is "incapable of self-care" if she/he requires active assistance or supervision to provide daily self-care in three or more of the activities of daily living or instrumental activities of daily living, such as grooming and hygiene, bathing, dressing and eating, cooking and cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, etc.).

☐ Military Service Leave (attach Military Service Notification) ☐ Emergency Rescue Personnel Leave

☐ To assist a child, spouse, or parent who is a member of the National Guard or Reserves with a "qualifying exigency" related to active duty or a call of active duty status in support of a contingency operation.
Check one: ☐ Child ☐ Spouse ☐ Parent

☐ To care for a child, spouse, parent, or "next of kin" service member of the United States Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty (up to 26 weeks of leave).
Check one: ☐ Child ☐ Spouse ☐ Parent ☐ Next of Kin (as defined by FMLA regulations)

☐ Donor Leave: Check one: ☐ Bone Marrow Donation ☐ Organ Donation

☐ Other Reason (including personal, educational, and death of family member). Explain:

EMPLOYEE SIGNATURE REQUIRED ON NEXT PAGE

Initials:

READ THE TERMS CAREFULLY BEFORE SIGNING BELOW.

Name (Last, First, Middle):		EE ID:	

I understand that:

1. I am bound by all the terms and conditions of the County's Leave of Absence Program and that the County has the right to grant or deny any request for a leave of absence or an extension thereof, subject by provisions of the Federal Family Medical Leave Act, the State Family Rights Act, the State Pregnancy Disability Leave rights, applicable collective bargaining agreements, Article 22, Section 2203 of the County of Ventura Personnel Rules and Regulations, and the County Administrative Policy Manual.
2. I may be required to make premium payments directly to the County while on leave of absence. If I fail to make payments on a timely basis, coverage under that benefit will be canceled until I return from leave and deductions resume. If the County mistakenly pays any premiums on my behalf, I agree to repay the County directly or through wage/salary deduction.
3. The failure to return to work on the day following the "Date Leave Ends" may be considered inexcusable absence without leave and subject me to disciplinary action. I also understand that if I am absent from work without authorization for three (3) days or two (2) consecutive twenty-four hour work shifts beginning with the day following the "Date Leave Ends" I have entered on the front of this form, the County may deem that I have voluntarily abandoned my job under Article 22, Section 2203, of the County of Ventura Personnel Rules and Regulations.
4. Failure to provide a complete and sufficient medical certification within 15 calendar days of this request may result in a denial of my leave of absence request. I further understand that I may be required to provide periodic reports on my status and intent to return to work. I agree to notify BOTH, my supervisor and leave of absence coordinator of my availability to return to full or restricted duty if I am released by my doctor prior to the end of an approved medical leave of absence.
5. I agree to comply with the County's Integration policy to which employees may use approved leave bank hours in conjunction with disability benefits that result in the employee's full biweekly base pay. The policy prevents employees from using leave bank hours that result in pay that is greater than their biweekly base rate. I understand that the appropriate use of your leave bank hours must be because of and consistent with the leave granted and that I have provided my department with payroll instructions during my leave of absence.
6. My dependent(s) eligibility for health care coverage is contingent on my submitting the proper forms within 31 days of (1) acquiring a new dependent (birth, marriage, placement for adoption, permanent legal custody), (2) a current dependent losing eligibility (divorce, dependent child turns age 26, death), even when the event occurs during my leave of absence.
7. I must comply with the Flexible Benefits Program Open Enrollment rules even if I am on leave of absence. Any applicable forms must be completed and submitted during the open enrollment period, not when I return from leave of absence and failure to comply may jeopardize my participation.
8. I agree to notify my department of any change of address and/or phone number. I understand and agree that all communications from the County of Ventura will be sent to the address I have on file and that I am responsible for acknowledging information sent to the address on file.

I affirm that I have read, understand and agree to the terms of this request as stated above and on the front of this form. I have been given a copy of the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA) and if applicable, the California Pregnancy Disability Leave Notice to Employees (PDL).

Employee Signature: **Date:**

SECTION III:

☐ **Leave request approved** ☐ **Leave request approved *WITH CHANGES*** ☐ **Leave request denied**

Department Signature:	EE ID:		Date:	
Department Signature:	EE ID:		Date:	
CEO / HR Signature:	EE ID:		Date:	