

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): _____

Current Leave Balances

Table with 2 columns: Leave Type, Balance. Rows include PPE Date, Vac, Sick, COMP.

Reason: (Column A) Employee

(Column B)

(Column C)

- [] Work-Related Injury/Illness [] Spouse / Domestic Partner Illness/Injury [] Military Leave
[] NonWork-Related Injury/Illness [] Dependent Child's Illness/Injury [] Education Leave
[] Pregnancy Disability [] Parent's Illness/Injury [] Sabbatical Leave
[] 4850 Leave [] Bonding Leave [] Other

FMLA 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.

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 will forward a copy of this completed form to the Retirement Office for calculation of the cost to purchase that time.

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 Date: #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 office for Military