COUNTY OF SAN LUIS OBISPO
DEPARTMENT OF HUMAN RESOURCES

LEAVE OF ABSENCE REQUEST FORM

Leaves of Absence (Absence of 5 business days or more)
☐ INITIAL Request ☐ EXTENSION Request

SECTION 1: REQUEST (To be completed by the EMPLOYEE)		
Employee Name:	Employee Number:	Today's Date:
Department:	Job Title:	Primary Email:

NOTE: Any leave request requires your department head's approval. Any leave of absence WITHOUT PAY will affect retirement deposits as well as Retirement Service Credits. Contact Pension Trust immediately to make arrangements to receive full credits.

1. Anticipated Begin Date of Leave:_____ **2. Anticipated Return to Work Date**: _____

3. Type of Leave: (PLEASE CHECK ONE)
☐ Leave on Continuous Basis ☐ Intermittent Leave of Absence ☐ Reduced Work Schedule (EXPLAIN): _____

4. Reason for Leave of Absence: (PLEASE CHECK ONE)
☐ Serious Illness or Injury of Employee
☐ Pregnancy Disability Leave
Due Date/DOB (REQUIRED):
☐ Bonding, Adoption, or Foster Placement of a Child
Date of Birth/Adoption/Placement (REQUIRED):
☐ Care of Family Member:
☐ Non-FMLA or non-medical leave of absence
☐ Workers' Compensation
☐ Military Exigency for self or covered family member
☐ Military Service (MUST PROVIDE OFFICIAL ORDERS FOR DUTY)
☐ Military Caregiver

5. Please indicate how many/which type of paid hours you would like to have coded OR the number of hours determined for coordination with State Disability Insurance/Paid Family Leave/Temporary Total Disability:
NOTE: Employees on approved FMLA/CFRA/PDL must code a minimum of 20 hours of paid time (sick/vacation/comp, etc.) unless leave balances are exhausted or employee is coordinating time if on SDI/PFL/TTD.

☐ _____hours/week of available balances ☐ _____ hours/week of available balances/Coordinating with SDI
☐ Other (EXPLAIN): _____

Under Federal law, for the first 12 weeks of Family Leave only, the County will continue to pay the County's monthly cafeteria plan contribution which is paid directly to County-sponsored insurance plans. Family Leave and Pregnancy Leave may be combined to the maximum provided by State and Federal Law. An extended Leave of Absence may result in the expiration of your health benefits. Contact the Auditor's Office to continue coverage at your own expense. If you choose not to maintain the coverage, your health insurance will be canceled. You must re-enroll in the health, dental and vision plans upon returning to work.

It is the employee's responsibility to keep in contact with their department regarding their return to work date and/or if a leave extension is needed. Failure to do so within a reasonable and timely manner will be considered grounds for possible disciplinary action.

Until you receive notice that your leave of absence has been approved, continue to report your absence to your department, according to your department's absence reporting policy. **Reporting your absence to your department does not guarantee approval of your leave.**

I request leave of absence and timecard coding as described above:

_____ _____
Signature of Employee Date

_____ _____
Signature of Department Head Date

EMPLOYEE: PLEASE SUBMIT THIS REQUEST AND MEDICAL CERTIFICATION TO YOUR DEPARTMENT PAYROLL COORDINATOR FOR PROCESSING

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Employee Name: _____ Employee Number: _____

SECTION 2: ELIGIBILITY (To be completed by the DEPARTMENT PAYROLL COORDINATOR)

NOTE: This section is not required for non-medical leaves of absence.

1. ☐ **ELIGIBLE:** _____ has verified your eligibility with Downtown HR (FMLA/CFRA/PDL only),
Department Payroll Coordinator
You have _____ of FMLA/CFRA/PDL as of the date of this request.

2. ☐ **NOT ELIGIBLE:** You are not eligible for the following reason(s): (PLEASE CHECK/FILL-IN ONE)

☐ **You have worked less than 1250 hours in the last 12 months.** As of _____ you have actually worked _____ hours in the 12 month period immediately preceding the start date of your leave.

☐ **You do not have 12 months of employment.** As of _____ you have worked _____ months with the County.

☐ **You do not have an FMLA/CFRA qualifying event for your leave.**

☐ **You have exhausted all your FMLA/CFRA entitlement for the year.** As of _____ you exhausted _____ hours of your entitled leave for the year.

SECTION 3: APPROVAL (To be completed by Human Resources Department)

NOTE: This section should not be completed until the employee's Medical Certification has been reviewed.

❑ **APPROVED**
❑ **NOT APPROVED**

Comment(s):

_____ _____
Signature of Human Resources Director or Designee Date

SECTION 4 (IF APPLICABLE): RETURN TO WORK CHECKLIST (To be completed by the Dept Payroll Coordinator)

❑ Upon approval from HR Department, send employee designation notice. Date completed: _____
❑ Send notice to employee reminding them to submit a medical certification on return to work. Date completed: _____
❑ Received medical certification returning employee to full duty with no restrictions (no further action needed)
Return to Duty Date: _____
❑ Received medical certification returning employee to work with restrictions.
- ❑ HR Department notified
- ❑ Accommodation paperwork sent to employee for completion. Date: _____
- ❑ Accommodation paperwork received. Date: _____
- ❑ Interactive Process Meeting scheduled. Who will be attending? _____
- ❑ Interactive Process Meeting completed. Date: _____
- ❑ Temporary Accommodation Agreement signed by department and employee. Date: _____
- ❑ Received medical certification returning employee to full duty. Date: _____

DEPARTMENT PAYROLL COORDINATOR: PLEASE SUBMIT REQUEST AND MEDICAL CERTIFICATION TO COUNTY HUMAN RESOURCES