

COUNTY OF IMPERIAL REQUEST FOR LEAVE OF ABSENCE

Name:	Social Security #:	Date:
Job Title:	Department:	Employee #:
Immediate Supervisor:	Work Phone Number:	Date of Hire:
Mailing Address:		Daytime/Mobile Number: ()

Initial Request **Extension Request**

Date Leave of Absence Begins:	Date Leave of Absence Ends:	Expected Return to Work Date:
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Leave Requested is <input type="checkbox"/> With Pay <input type="checkbox"/> Partial Pay # _____ hrs per pp <input type="checkbox"/> Without Pay ** Contact HR to arrange insurance premium payments during leave (760- 482-4488)	If leave is with pay, use hours as follows: <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>Accrued Sick Leave</u></td> <td style="text-align: center;"><u>Accrued Vacation</u></td> <td style="text-align: center;"><u>Accrued Comp Time</u></td> <td style="text-align: center;"><u>Accrued Admin Leave</u></td> </tr> <tr> <td><input type="checkbox"/> _____ Hrs pay period</td> <td><input type="checkbox"/> _____ Hrs pay period</td> <td><input type="checkbox"/> _____ Hrs pay period</td> <td><input type="checkbox"/> _____ Hrs pay period</td> </tr> <tr> <td colspan="2">Period Starting _____</td> <td colspan="2">Period Ending _____</td> </tr> </table> <p style="text-align: right; font-size: small;">**Please attach pay schedule if needed</p>	<u>Accrued Sick Leave</u>	<u>Accrued Vacation</u>	<u>Accrued Comp Time</u>	<u>Accrued Admin Leave</u>	<input type="checkbox"/> _____ Hrs pay period	<input type="checkbox"/> _____ Hrs pay period	<input type="checkbox"/> _____ Hrs pay period	<input type="checkbox"/> _____ Hrs pay period	Period Starting _____		Period Ending _____	
<u>Accrued Sick Leave</u>	<u>Accrued Vacation</u>	<u>Accrued Comp Time</u>	<u>Accrued Admin Leave</u>										
<input type="checkbox"/> _____ Hrs pay period	<input type="checkbox"/> _____ Hrs pay period	<input type="checkbox"/> _____ Hrs pay period	<input type="checkbox"/> _____ Hrs pay period										
Period Starting _____		Period Ending _____											

Type of Leave:			
<input type="checkbox"/> 1. Illness/Injury -Not Work Related	<input type="checkbox"/> 4. Pregnancy Disability	<input type="checkbox"/> 7. Military <small>** Attach Military Form</small>	<input type="checkbox"/> 10. Personal
<input type="checkbox"/> 2. Illness/Injury – Work Related <small>** Only if claim has been approved or accepted</small>	<input type="checkbox"/> 5. Newborn Bonding	<input type="checkbox"/> 8. Bereavement	<input type="checkbox"/> 11. Other : _____
<input type="checkbox"/> 3. Care for ill Parent/ Spouse/ Child/Domestic Partner	<input type="checkbox"/> 6. Adoption/Foster Child Bonding	<input type="checkbox"/> 9. Educational	

Provide Details of Request (Including requested intermittent or reduced work schedule):

I voluntarily request a leave of absence for the reason(s) stated above. I understand my rate of pay will be subject to any general increases or decreases in wage rates that become effective during my absence from work; that I am not to accept any other employment of any kind; that my return to work will be subject to employment conditions existing at the time of such return.

I (_____ employee's initials) understand that the leave reasons numbers 1 to 6 will be designated as FMLA/CFRA leave if I meet the criteria (medical certification may be required) and that my FMLA/CFRA leave will begin on the first day of the qualifying leave. I further understand that it is my responsibility to make arrangements with the Benefits Unit of the Human Resources Department for payment of group insurance premiums during this leave period, if necessary.

Signature: _____ **Date:** _____

Department Head	
<input type="checkbox"/> Approve <input type="checkbox"/> Not Approve	Signature: _____ Date: _____
<input type="checkbox"/> Approve with the following restrictions: _____	
<small>***If leave is less than fifteen (15) calendar days, only Department Head authorization required.</small>	

Director of Human Resources	
<input type="checkbox"/> Approve <input type="checkbox"/> Not Approve	Signature: _____ Date: _____
<input type="checkbox"/> Approve with the following restriction: _____	
Eligible for FMLA/CFRA <input type="checkbox"/> Yes <input type="checkbox"/> No	