

**COUNTY OF IMPERIAL**  
**REQUEST FOR LEAVE OF ABSENCE**

Name:	Last 4 digits of Social Security #:	Date:
Job Title:	Department:	Employee #:
Immediate Supervisor:	Personal Email Address:	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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<b>Leave Requested is</b>	<b>If leave is with pay, use hours as follows:</b>		
<input type="checkbox"/> With Pay <input type="checkbox"/> Partial Pay # _____ hrs per pp <input type="checkbox"/> Without Pay	<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		
** Contact HR to arrange insurance premium payments during leave (442-265-1148)	Period Starting _____	Period Ending _____	**Please attach pay schedule if needed

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

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

I voluntary 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:** \_\_\_\_\_

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

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