COUNTY OF IMPERIAL
REQUEST FOR LEAVE OF ABSENCE

Name:		**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:**

Leave Requested is

☐ With Pay
☐ Partial Pay #_____hrs per pp
☐ Without Pay

**** Contact HR to arrange insurance premium payments during leave (442-265-1148)**

If leave is with pay, use hours as follows:

Accrued Sick Leave ☐ _____ Hrs pay period
Accrued Vacation ☐ _____ Hrs pay period
Accrued Comp Time ☐ _____ Hrs pay period
Accrued Admin Leave ☐ _____ Hrs pay period

Period Starting _____ Period Ending _____

**Please attach pay schedule if needed

Type of Leave:

☐ 1. Illness/Injury -Not Work Related
☐ 2. Illness/Injury – Work Related
** Only if claim has been approved or accepted
☐ *3. Care for Ill Parent/ Spouse/ Child/Domestic Partner*
☐ 4. Pregnancy Disability
☐ 5.Newborn Bonding
☐ 6. Adoption/Foster Child Bonding
☐ 7. Military
** Attach Military Form
☐ 8. Bereavement
☐ 9. Educational
☐ 10. Personal
☐ 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:** _____

Department Head

☐ Approve ☐ Not Approve Signature: _____ Date: _____

☐ Approve with the following restrictions: _____

***If leave is less that fifteen (15) calendar days, only Department Head authorization required.

Director of Human Resources

☐ Approve ☐ Not Approve Signature: _____ Date: _____

☐ Approve with the following restriction: _____

Eligible for FMLA/CFRA ☐ ***Yes*** ☐***No***