COUNTY OF IMPERIAL
REQUEST FOR LEAVE OF ABSENCE

SECTION 1 — EMPLOYEE INFORMATION

Full Name: **Date:**

Job Title: **Department:** **Employee ID #:**

Immediate Supervisor: **Email Address:** **Date of Hire:**

Mailing Address: **Daytime/Mobile Phone Number:**

SECTION 2 — LEAVE DATES

☐ Initial Request ☐ Extension Request ☐ Intermittent

Date Leave of Absence Begins:	**Date Leave of Absence Ends:**	**Expected Return to Work Date:**

SECTION 3 — TYPE OF LEAVE

☐ **1.** Illness / Injury — Not Work Related

☐ **2.** Illness / Injury — Work Related (Workers' Compensation)
Date of Injury/Illness: _____

☐ **3.** Care for Ill Parent/Spouse/Child/Other Eligible Family Member

☐ **4.** Pregnancy Disability

☐ **5.** Newborn Bonding

☐ **6.** Adoption / Foster Child Bonding

☐ **7.** Military ★ Attach Military Form

☐ **8.** Other _____

SECTION 4 — OPTIONAL: Additional Information provide any non-medical information relevant to your leave request.

_____

SECTION 5 — EMPLOYEE ACKNOWLEDGMENT & SIGNATURE

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; that I am not to accept any other employment of any kind; and that my return to work will be subject to employment conditions existing at the time of return. I further understand that I am required to notify my supervisor how I elect to be paid while on leave, in accordance with County policy and available leave balances.

I _____ (employee's initials) understand that my leave request may be designated as Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), and/or Military Leave, as applicable, if I meet the eligibility requirements. I understand that medical and/or military certification may be required to support my leave request. If my leave is related to a work-related injury or illness, my Workers' Compensation claim is subject to determination by the County's Workers' Compensation Administrator. I further understand that, where permitted by law, applicable leave entitlements may run concurrently beginning on the first day of the qualifying event.

Employee Signature: _____ Date: _____

SECTION 6 — DEPARTMENT NOTIFICATION & ACKNOWLEDGMENT

NOTICE: The department acknowledges receipt of the employee's leave request and is aware of the anticipated absence. The department may assist with coordinating departmental operations, timekeeping, and communication with Human Resources, as appropriate. Final determination of leave eligibility and designation is the responsibility of Human Resources.

Department Designee (Print Name): _____ Signature: _____ Date: _____

SECTION 7 — HUMAN RESOURCES (HR Use Only)

Approve with the following restrictions:

Eligible for FMLA / CFRA / PDL: ☐ Yes ☐ No Leave Designation: _____

Signature: _____ Date: _____

This determination is based on information available at the time of review and may be updated as additional documentation is received.