SAN JOAQUIN COUNTY
Greatness grows here.

Human Resources Division

Request for Leave of Absence

Section I: For Completion by the EMPLOYEE

Employee Name:	**Employee ID Number:**
Employee Mailing Address:	**Primary Contact Number(s):**
Department:	**Personal Contact Email:**
County Job Title:	**Date Request Submitted:**
Supervisor Name:	**Supervisor Phone:**

☐ New Request or ☐ Request for Extension of Leave

Date Leave Begins: _____ Date Leave Ends: _____ Estimated Return to Work: _____

Type of Leave Request: ☐ Continuous Leave ☐ Intermittent or Reduced Schedule

If your request is being submitted less than 30 days prior to the start of your leave, please specify the reason for the timing:

I am requesting a leave of absence for the following reason: *(check one)*

☐ **Personal Medical:** My leave is related to my own serious health condition.

Is the injury or illness work-related? ☐ No ☐ Yes, date injury or illness occurred: _____

☐ **Immediate Family Member:** My leave is to care for an immediate family member who has a serious health condition.

Check one: ☐ Spouse ☐ Registered domestic partner ☐ Child ☐ Child +18 years or older ☐ Parent ☐ Parent-in-law

☐ Grandparent ☐ Grandchild ☐ Sibling

☐ **Pregnancy Disability:** My disability is due to pregnancy, childbirth, or a related condition.

☐ **Bonding:** My leave is for and following the birth of my child or the placement of a child with me for adoption or foster care ("bonding" leave).

☐ Date of birth (or expected date of birth): _____; or ☐ Date of placement (or expected date of placement): _____

☐ **Military Family Medical Condition:** A serious injury or illness incurred or aggravated in the line of duty while on active duty in the armed forces affecting my: ☐ Spouse ☐ Registered domestic partner ☐ Child ☐ Parent ☐ Next of kin who is a service member in the armed forces or veterans of the armed forces.

☐ **Military Qualifying Exigency:** A qualifying exigency resulting from active duty or call to active duty in the armed forces in a foreign country of my: ☐ Spouse ☐ Registered domestic partner ☐ Child ☐ Parent

☐ **Military Leave:** Employee request related to active duty. *(A copy of the Military Orders must be attached.)*

☐ **Personal Leave:** Attach separate explanation, statement, or relevant documentation.

☐ **Educational Leave:** Attach separate explanation, statement, or relevant documentation.

Wage Replacement Benefits: *(check one)*

☐ I **have applied or intend to apply** for wage replacement benefits, such as State Disability Insurance (SDI), or Paid Family Leave (PFL).

☐ I **do not intend** to file a claim for wage replacement benefits. I understand that I must use the required amount of paid leave accruals before taking leave without pay following the appropriate bargained MOU or Board resolution.

☐ I understand that if I have filed or plan to file a workers' compensation claim, I must complete a *Notice of Leave of Absence for Temporary Disability Indemnity Payment (FORM 29).*

I understand the following:

General Notices: _____ Initials

- The County must approve my leave request, and I may be required to meet eligibility requirements and/or submit a certification or supporting documentation to qualify for leave.
- Depending on the type of leave requested, I may be required to use a minimum amount of available paid leave accruals before taking leave without pay.
- If an extension of leave is needed, I am required to submit a Request for Leave of Absence form and the required documentation at least two (2) business days before my anticipated return date.
- Any leave of absence may be revoked by the Director of Human Resources upon written request of the Department Head supported by evidence the reason for granting leave was misrepresented or has ceased to exist.

Health Benefits: _____ Initials

- Depending on the type of leave approved and the amount of paid time required, I may be required to meet eligibility requirements to retain the employer-paid premium contributions as outlined in the appropriate MOU or Board resolution.
- I am responsible for paying my full share of premiums. The amount of paid leave must be enough to cover my full share of premiums for each benefit plan (e.g. medical, dental, vision), or the premiums will not be deducted from my paycheck (e.g. you do not have the option to pay a portion of your share of medical premiums and the remaining balance over the counter).
- To maintain my coverage, I must make arrangements with the County's Benefits Office at (209) 468-9987 or employeebenefits@sjgov.org to pay my share of the premiums no later than the Monday of the County's pay week. My group health insurance will be terminated unless payment is timely. Once my group health insurance is termed, I have 30 days from the date of termination to make my full premium payments.
- If I experience a change in status, such as birth, adoption, marriage, or registered domestic partnership, I must enroll that dependent and provide proper documentation to Human Resources within 60 days from the date of the qualifying life event.

Wage Replacement Benefits: _____ Initials

- If I am receiving wage replacement benefits such as State Disability Insurance (SDI) or Paid Family Leave (PFL), I may elect to use paid leave accruals as allowed by policy/MOU/Board resolutions in situations where the use of accrued leave is not required.
- I understand that I must notify my department's leave coordinator/payroll personnel that I am receiving wage replacement benefits.
- I understand if I use paid leave accruals while receiving wage replacement benefits, I should not receive more than 100% of my normal salary.
- If I do not make an election regarding wage replacement benefits, the default will be to use the minimum amount of available paid leave accruals required each pay period while on an approved leave following the appropriate MOU or Board resolution.

NOTE: Employees are responsible for determining the number of hours (e.g. paid leave accruals) required to cover the employee's share of premiums and any other normal payroll deductions while on leave.

I have attached the required certification and/or supporting documentation with this request: ☐ Yes ☐ No

_____ _____

Employee's Signature *Date*

SECTION II: FOR DEPARTMENT USE ONLY

County Hire Date: _____ Employee Status:_____ (i.e. tm, pt, pb, pm, etc.)

Does this leave qualify under the FMLA/CFRA? ☐ YES ☐ NO

☐ Medical information/certification attached ☐ Proof of birth or placement of a child

☐ FMLA Administration Module Updated

If leave extension, indicate the initial start date of leave:_____

During the preceding 12 months, the employee has used _____ hours of paid/unpaid leave, which qualifies under FMLA/CFRA.

For Personal Leave Only:

Date of Last Evaluation: _____ Rating: ☐ Satisfactory ☐ Unsatisfactory

Continuous Service: ☐ Less than 12 months ☐ 12 months or more

Dates of Leave: ☐ Approved as requested ☐Modified: From _____ To _____ ☐ Denied

Leave Approved as Follows:

☐ FMLA ☐ CFRA Leave – Medical Certification Attached

☐ Pregnancy Disability Leave

☐ FMLA ☐ CFRA Bonding Leave – Documentation Attached

☐ Medical Leave Non-FMLA/Non-CFRA – Medical Certification Attached

☐ Extension of Leave – Documentation Attached

☐ Personal Leave up to 30 Days

☐ Personal Leave over 30 Days Recommended

☐ Personal Leave for Education

☐ Military Leave – Orders Attached

Signature-Appointing Authority or Designee:	Date:

FOR THE HUMAN RESOURCES DIVISION USE ONLY

Eligible for Protected Leave insurance coverage from _____ to _____ Protective Leave Ends: _____

( ) Leave approved as recommended ( ) Other: _____ Dates:_____

_____ _____

Authorized Signature Date